MEETING OF THE BOARD
27 June 2018

Venue: Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu

CMDHB BOARD MEMBERS
Mark Gosche – Chair
Dr Lyn Murphy – CMDHB Board Member
Apulu Reece Autagavaia – CMDHB Board Member
Dr Ashraf Choudhary – CMDHB Board Member
Catherine Abel-Pattinson – CMDHB Board Member
Colleen Brown – CMDHB Board Member
Dianne Glenn – CMDHB Board Member
George Ngatai – CMDHB Board Member
Katrina Bungard – CMDHB Board Member

CMDHB MANAGEMENT
Gloria Johnson – acting Chief Executive
Margaret White – Chief Financial Officer
Vanessa Thornton – Chief Medical Officer
Jenny Parr – Director of Patient Care, Chief Nurse & Allied Health Professions Officer
Dinah Nicholas – Board Secretary

PART 1 – Items to be considered in public meeting

AGENDA

BOARD ONLY SESSION (8.00 – 9.00am) | Page No.
--- | ---
9.10am RESOLUTION TO EXCLUDE THE PUBLIC | 3

10.30am 1. GOVERNANCE

1.1 Apologies
1.2 Disclosures of Interest
1.3 Specific Interests | 4
5-6
7

2. BOARD MINUTES

10.30 – 10.33am 2.1 Confirmation of Minutes of the Meeting of the Board – 16 May 2018

10.33 – 10.35am 2.2 Action Items Register

10.35 – 10.40am 2.3 Minutes Community & Public Health Advisory Committee – 11 April 2018 (Colleen Brown) | 8-16
17-19
20-26

3. EXECUTIVE REPORTS

10.40 – 10.50am 3.1 Chief Executive Officer’s Report (Gloria Johnson) | 27-32

10.50 – 11.00am 3.2 Health and Safety Performance Report (Elizabeth Jeffs) | 33-55

11.00 – 11.10am 3.3 Corporate Affairs and Communications Report (Donna Baker) | 56-67

4. PERFORMANCE REPORTS

11.10 – 11.20am 4.1 Finance and Corporate Business Report (Margaret White) | 68-76

5. DECISION PAPERS

11.20 – 11.30am 5.1 2018/19 Capital Plan (Margaret White) | 77-84

11.30 – 11.35am 5.2 Proposal to Establish a Capital Works Oversight Sub-Committee (Margie Apa) | 85-90

11.35 – 11.40am 5.3 Alice Nelson Charitable Trust (Margaret White) | 91-123

11.40 – 11.50am 5.4 Metro Auckland Urgent Care After Hours Procurement (Benedict Hefford) | 124-126

11.50 – 11.55am 5.5 Regional Internal Audit FY2019 Audit Plan (Margaret White) | 127-134

11.55 – 12.00pm 5.6 Regional Internal Audit FY2019 Budget (Margaret White) | 135-136

12.00 – 12.15pm 5.7 General Medicine Bed Capacity (Phillip Balmer/Brad Healey) | 137-150

12.15 – 12.25pm 5.8 Turn Around Plan (Kathryn de Luc/Gloria Johnson) | 151-152

6. INFORMATION PAPERS

6.1 Safety for All – Goal of Zero Seclusion 2020 | 153-154

6.2 Social Investment Board Quarterly Report | 155-161
<table>
<thead>
<tr>
<th>7. RESOLUTION TO EXCLUDE THE PUBLIC</th>
<th>162-164</th>
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</thead>
<tbody>
<tr>
<td>Lunch Break (12.25 – 1.00pm)</td>
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</table>
Resolution to Exclude the Public

Resolution:
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| Strategic Workshop                       | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Negotiations  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial negotiations). |

[NZPH&D Act 2000 Schedule 3, S32(a)]  
[Official Information Act 1982 S9(2)(j)]
# Board Member Attendance Schedule 2018

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>28 Feb</th>
<th>Mar</th>
<th>4 Apr</th>
<th>16 May</th>
<th>27 Jun</th>
<th>July</th>
<th>8 Aug</th>
<th>19 Sep</th>
<th>31 Oct</th>
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<tbody>
<tr>
<td>Mark Gosche (Chair)**</td>
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<td>Colleen Brown</td>
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<td>Dianne Glenn</td>
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<td>Reece Autagavaia</td>
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<td>Catherine Abel-Pattinson</td>
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<td>Katrina Bungard</td>
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<td>Dr Ashraf Choudhary</td>
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<td>Rabin Rabindran*</td>
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<td>Mark Darrow*</td>
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** Appointed effective 3.5.2018
* No longer on the Board effective 2.5.2018
# BOARD MEMBERS’ DISCLOSURE OF INTERESTS

27 June 2018

**New items in red italics**

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</table>
| Mark Gosche, Chair | • Trustee, Mt Wellington Licensing Trust  
• Director, Mt Wellington Trust Hotels Ltd.  
• Director, Keri Corporation Ltd  
• Trustee, Mt Wellington Charitable Trust  
• Chief Executive, Vaka Tautua  
• Trustee, Pacific Information Advocacy & Support Services Trust  
• Life Member, Labour Party  
• Life Member, ETU Union  
• Deputy Chair & Board Member, Housing NZ |
| Dr Ashraf Choudhary | • Board Member, Otara-Papatoetoe Local Board  
• Member, NZ Labour Party  
• Chairperson, Advisory Board Pearl of Island Foundation  
• Co-Patron, Bharatiya Samaj Charitable Trust |
| Catherine Abel-Pattinson | • Board Member, Health Promotion Agency  
• National Party Policy Committee Northern Region  
• Member, NZNO  
• Member, Directors Institute  
• Husband (John Abel-Pattinson), Director, Blackstone Group Ltd  
• Husband, Director, Blackstone Partners Ltd  
• Husband, Director, Bspoke Ltd  
• Husband, Director, 540 Great South Ltd  
• Husband, Director, Barclay Suites  
• Husband, Chairman, Lifetime Design  
• Husband, Director, various single purpose property owning companies |
| Colleen Brown | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
• Member, NZ Down Syndrome Association  
• Husband, Determination Referee for Department of Building and Housing  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group  
• District Representative, Neighbourhood Support NZ Board  
• Chair, Rawiri Residents Association |
<table>
<thead>
<tr>
<th>Name</th>
<th>Roles</th>
</tr>
</thead>
</table>
| Dianne Glenn            | • Member, NZ Institute of Directors  
                         • Life Member, Business and Professional Women Franklin  
                         • Member, UN Women Aotearoa/NZ  
                         • President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
                         • Life Member, Ambury Park Centre for Riding Therapy Inc.  
                         • Member, National Council of Women of New Zealand  
                         • Justice of the Peace  
                         • Member, Pacific Women’s Watch (NZ)  
                         • Member, Auckland Disabled Women’s Group  
                         • Life Member of Business and Professional Women NZ |
| George Ngatai           | • Director, Transitioning Out Aotearoa  
                         • Director, The Whanau Ora Community Clinic  
                         • Chair, Safer Aotearoa Family Violence Prevention Network  
                         • Huakina Development Trust (Partnership Clinic)  
                         • Community Organisation Grants Scheme (Auckland)  
                         • Lotteries Community (Auckland)  
                         • Board Member, Counties Manukau Rugby League Zone  
                         • Member, NZ Maori Council |
| Katrina Bungard         | • Chairperson MECOSS – Manukau East Council of Social Services.  
                         • Deputy Chair Howick Local Board  
                         • Member of Amputee Society  
                         • Member of Parafed disability sports  
                         • Member of NZ National Party |
| Dr Lyn Murphy           | • Member, ACT NZ  
                         • Director, Bizness Synergy Training Ltd  
                         • Director, Synergex Holdings Ltd  
                         • Trustee, Synergex Trust  
                         • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)  
                         • Member, New Zealand Association of Clinical Research (NZACRes)  
                         • Senior Lecturer, AUT University School of Inter professional Health Studies  
                         • Member, Public Health Association of New Zealand |
| Reece Autagavaia        | • Member, Pacific Lawyers’ Association  
                         • Member, Labour Party  
                         • Trustee, Epiphany Pacific Trust  
                         • Trustee, The Good The Bad Trust  
                         • Member, Otara-Papatoetoe Local Board  
                         • Member, District Licensing Committee of Auckland Council  
                         • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation |
| Ken Whelan, Crown Monitor| • Board Member, Royal District Nursing Service NZ  
                         • Contracts with Francis Health & GE Healthcare (mainly Australia & Asia) |
### BOARD MEMBERS’ REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

**Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 27 June 2018**

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katrina Bungard</td>
<td>Turn Around Plan</td>
<td>Chair of MECOSS</td>
<td>16 May 2018</td>
<td>That Katrina Bungard’s specific interest be noted and that the Board agree that she will depart the room when this particular item is discussed.</td>
</tr>
<tr>
<td>Catherine Abel-Pattinson</td>
<td>Whaanau Accommodation Options at MMH</td>
<td>Catherine’s husband owns a business that has hotel/motels in the Counties Manukau catchment area that are from time to time used for CM Health or WINZ clients.</td>
<td>4 April 2018</td>
<td>That Catherine Abel-Pattinson’s specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Apulu Reece Autagavaia</td>
<td>Transform Manukau Puhunui Stage 1</td>
<td>Apulu Reece Autagavaia declared a specific interest, being a Member of the Otara-Papatoetoe Local Board.</td>
<td>25 October 2017</td>
<td>That Apulu Reece Autagavaia’s specific interest be noted.</td>
</tr>
<tr>
<td>Dianne Glenn</td>
<td>Transform Manukau Puhunui Stage 1</td>
<td>Mrs Glenn declared a specific interest, being the President of Friends of Auckland Botanic Gardens and Chair of the Friends Trust.</td>
<td>25 October 2017</td>
<td>That Mrs Glenn’s specific interest be noted but not seen as a conflict of interest.</td>
</tr>
<tr>
<td>Reece Autagavaia</td>
<td>RMO Industrial Action</td>
<td>Mr Autagavaia declared a specific interest in relation to this item as his brother is a Junior Doctor at Middlemore Hospital.</td>
<td>15 February 2017</td>
<td>That Mr Autagavaia’s specific interest be noted.</td>
</tr>
</tbody>
</table>
Minutes of the Meeting of the Counties Manukau District Health Board

Wednesday, 16 May 2018

Held at Counties Manukau DHB, Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT
Mark Gosche (Board Chair)
Ashraf Choudhary
Colleen Brown
Catherine Abel-Pattinson
Dianne Glenn
George Ngatai
Lyn Murphy
Katrina Bungard
Apulu Reece Autagavaia

ALSO PRESENT
Gloria Johnson (acting Chief Executive)
Margaret White (Chief Financial Officer)
Jenny Parr (Director Patient Care, Chief Nurse & Allied Health Professions Officer)
Vanessa Thornton (acting Chief Medical Officer)
Dinah Nicholas (Board Secretary)
Mark Whelan (Crown Monitor)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT
Fiona Thomas (NZ Doctor), Sarah Robson (Radio New Zealand), Jarred Williamson (STUFF) and Cleo Fraser (NEWSHUB.)

APOLOGIES
There were no apologies received for this meeting.

WELCOME
George Ngatai opened the meeting with a karakia.

The Chair welcomed all those present and addressed the media representatives present advising that, as per the CMDHB Standing Orders ‘representatives of news media are entitled to attend any meeting or any part of a meeting where the public is not excluded for the purpose of reporting it for any news media however, news media are asked to notify their presence to the Chair prior to the commencement of the meeting as a courtesy and no recording by television or video or audio or photography may occur unless approved by the Chair prior to the commencement of the meeting’. He confirmed he was happy with the meeting being recorded today but would expect a request to be sent through the Communications Manager in advance of further meetings.
DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS
The Disclosures of Interest were noted with no amendments.

Katrina Bungard noted a specific interest in relation to Item 2.6 on today’s Public Excluded agenda.

AGENDA ORDER AND TIMING
Items were taken in the same order as listed on the Agenda.

BOARD MINUTES

2.1 Minutes of the Meeting of the Board – 4 April 2018

Resolution (Moved: Dianne Glenn/Seconded: Colleen Brown)
That the Minutes of the Board Meeting held on the 4 April 2018 be approved.
Carried

2.2 Actions Arising from Previous Meeting
There were no actions arising from the previous meeting.

2.3 Draft Minutes Hospital Advisory Committee (23 April 2018)
The minutes were taken as read.

3 EXECUTIVE REPORTS

3.1 Chief Executive’s Report (Dr Gloria Johnson)
The report was taken as read. Dr Johnson summarised the following key areas:

Targets – some of the health targets are at risk of not being met, namely ED Length of Stay, Elective Surgery performance and Immunisation rates. It is hoped to catch up with the Immunisation rates however, it is unsure whether we can catch up on the Elective Surgery target due to the sustained pressure on services and the ED length of stay target due to the increase in the number of presentations at ED.

Fundamentals of Care – the overall organisation result was 75% across all nine standards with the highest rated standard being Comfort and Pain Management (83.7%) and the lowest Clinical Monitoring and Management (61.4%). A further review is planned for July to baseline the winter delivery of care. This review will look at the same nine standards across the same parts of the organisation to see how the results have changed over time. Ms Parr advised that the above result was due to the fact that there is a new and not well-embedded audit process, it was not that the observations were not being done and escalated.

Chlamydia Testing – Dr Thornton confirmed that Chlamydia is not usually transferred to a baby but mothers can miscarry due to infections particularly early on in pregnancy. Chlamydia is also linked to infertility.
Resolution (Moved: Katrina Bungard/Seconded: George Ngatai)

That the Board received the Chief Executive’s Report.

Carried

3.2 Health and Safety Performance Report (Elizabeth Jeffs)

The report was taken as read. Elizabeth Jeffs summarised the following key areas:

Board comments included:
- Attendance at H&S Orientation – the target is 100% and will be updated in the next report.
- OIA Request on Bullying Complaints – CM Health has the highest number of complaints of the three metro-Auckland DHBs which is concerning. Ms Jeffs advised that staff are asked to raise any issue that is of concern to them. This Friday is Pink Shirt Day (run by the Mental Health Foundation) and is being used as an opportunity to refresh all of the DHBs information around bullying and harassment. Part of the diversity work is to look at how we can have an inclusive culture to enable different cultures to Speak Up. The Values Programme is included in the Induction Day and it is mandatory for all staff to complete the Maaori and Pacific cultural training. Ms Jeffs confirmed that she is confident that the DHB is doing everything it can do.

The Board asked for a copy of the Welcome Day agenda to be included in the next Health & Safety Performance Report.

Dr Johnson advised that one of the key components in the Health Equity Campaign was about equity in the workforce and diversity and it would be timely to have a presentation to the Board on the Campaign as it is winding up shortly.

The Chair welcomed Ken Whelan, the Crown Monitor to the meeting at 10.50am.

Resolution (Moved: Dianne Glenn/Seconded: Lyn Murphy)

That the Board:

Received the Health and Safety Report for the period ending 31 March 2018.

Carried

3.3 Corporate Affairs and Communications Report (Donna Baker)

The report was taken as read. Donna Baker summarised the following key areas:

Bowel Screening – currently working with the National Screening Unit, MoH and other involved DHBs on raising awareness in our areas and rolling out information. A multi-channel approach focusses on print, media and social channels and is targeting Maaori & Pacific through a whole of family approach which is not how WDHB has done their campaign.
Dr Choudhary advised that he has been approached by Indian radio asking questions about some of the recent issues as there is very little information being made available in the Indian languages, or in fact, other languages. Ms Baker undertook to look into this further.

**Staff Flu Update** – as at 1 May, uptake was 46.7% which is not as good as we would have liked with some areas still sitting at 0% (Pacific Health, Localities and Women’s Health). Targeted communications are being sent to the staff who have yet to have a vaccination, a ‘please explain’ has been sent to the General Managers, a survey has been sent out to the staff who have not been vaccinated asking ‘why’ and a CEO blog has also been sent out. As part of our duty of care to our patients the expectation is that staff are vaccinated.

The Board asked to be provided with the data on the three areas where the Board’s desire was to have 100% uptake (Maternity, Paediatrics and ARHoP) in the next report.

**Breastscreening** – it was noted that the breastscreening campaign is for women between the ages of 45-69, not 65.

**Programme W&AT!** – the Board asked for further information on this programme.

**OIAs** – the DHB has received 48 requests for information in the last four days compared to 66 in the previous six-months. Additional resource has been brought on board to go through all the data and documentation for the OIAs as it is important that we meet our obligations under the Act.

**Resolution** (Moved: Catherine Abel-Pattinson/Seconded: Lyn Murphy)

That the Board:

Received the Corporate Affairs and Communication Report for the period 14 February to 22 March 2018.

Carried

### 4 PERFORMANCE REPORTS

#### 4.1 Finance and Corporate Business Report (Margaret White)

The paper was taken as read. Margaret White summarised the following areas:

*February result* – the result was slightly unfavourable to budget largely reflecting the continued acute pressure on the hospital particularly through ED and the back of the hospital. We are also seeing the same impact on the IDF flows into ADHB. The rest of trading is largely running to plan to deliver to the commitment to the bottom line. The forecast position remains on track overall to budget.

*Bad debts* – healthAlliance provide our non-resident/eligibility service and there are staff within the DHB who capture eligibility issues as patients are presenting to the hospital. There is a process to ensure that anyone with an eligibility query is essentially treated as ineligible until they are able to confirm otherwise by way of passport confirmation. The DHB accepts only acute ineligible and there would be very few exceptions where patients would come through from an elective sense.
With patients who are unable to pay on discharge their debt is managed through healthAlliance to secure payment. Often this is on time payment with some being extremely long term payment plans. If healthAlliance are unable to secure a payment mechanism (after three-months), the debts are transferred to BayCorp. This is not done lightly as it is sometimes very difficult for families but it is something we need to do because we are unable to accommodate that cost exposure.

**YTD Payments to Suppliers**
- **Outsourced personnel $6.5m unfavourable**—Ms White undertook to look into this further.
- **After hours $1.1m unfavourable**—this was due to the budget not being phased appropriately/timing issues.

**Resolution** (Moved: Catherine Abel-Pattinson/Seconded: George Ngatai)

That the Board:

Received the Finance and Corporate Business Report for the period ending 28 February 2018.

**Carried**

5  DECISION PAPERS

5.1  Audit Risk and Finance Committee - Draft Terms of Reference

The paper was noted.

Two slight amendments were suggested to the Terms of Reference.

It was felt that the Committee’s roles and responsibilities needed to be clarified/determined in relation to the Facilities Modernisation Programme (FMP) Sub-Committee and incorporated into the draft Terms of Reference.

The Board requested a copy of the previous FMP Sub-Committee Terms of Reference be provided for their discussion at the next Board meeting on 27 June.

**Resolution** (Moved: Ashraf Choudhary/Seconded: Colleen Brown)

That the Board:

Defer the decision on the Audit Risk and Finance Committee Draft Terms of Reference to the next Board meeting on 27 June 2018.

Agree to continue in the meantime under the current Terms of Reference dated 7 September 2017.

Appoint Mark Gosche as a member of the Audit Risk & Finance Committee.

**Carried**
6 RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Mark Gosche/Seconded: Lyn Murphy)

That the Crown Monitor, Mr Ken Whelan, be permitted to remain in the Public Excluded section of this meeting.

That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Excluded Minutes of 4 April 2018/Actions</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
</tr>
<tr>
<td>Public Excluded Minutes of the Hospital Advisory Committee and the Audit Risk &amp; Finance Committee</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
</tr>
<tr>
<td>Case for Immediate Demand</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td>Improving Outcomes for Patients with Chronic Conditions</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td>Resolution</td>
<td>Under Information Act 1982.</td>
<td>Commercial Activities</td>
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<tr>
<td>Immediate Demand Circular Resolution</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td>Galbraith Assessment Update</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to protect the confidentiality of advice tendered by officials.</td>
</tr>
<tr>
<td>Short term Histology Lab Relocation Business Case</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
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<td>Turn Around Plan Update &amp; Phase 2 Opportunities</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
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<td>Cash/Equity Injection</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to protect the confidentiality of advice tendered by officials.</td>
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<td>Ground Maintenance Contract</td>
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<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<th>Consent to Sale of Diaverum NZ Ltd Business</th>
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Carried
The public meeting closed at 11.45am.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD, BOARD MEETING HELD ON 16 MAY 2018.

BOARD CHAIR

27 June 2018
<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
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<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
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<tr>
<td>16 May 2018</td>
<td>Finance &amp; Corporate Business Report</td>
<td>Look into what is making up the $6.5m unfavourable Outsourced personnel costs noted in the May report.</td>
<td>27 June</td>
<td>Margaret White</td>
<td>Included in Item 4.1 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>16 May 2018</td>
<td>Corporate Affairs &amp; Communication Report</td>
<td>Bowel Screening- look into the availability of information in other languages. Provide an information report to Board on Programme W&amp;AT!</td>
<td>27 June</td>
<td>Donna Baker</td>
<td>Included in Item 3.3 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>16 May 2018</td>
<td>Health and Safety Report</td>
<td>The Board asked for a copy of the Welcome Day agenda to be included in the next H&amp;S Performance Report. One of the key components in the Health Equity Campaign is equity in the workforce and diversity. It would be timely to have a presentation to the Board on the campaign as it is winding up shortly.</td>
<td>27 June</td>
<td>Elizabeth Jeffs</td>
<td>Included in Item 3.2 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>4 April 2018</td>
<td>Finance &amp; Corporate Business Report</td>
<td>After Hours costs – unfavourable $1.080m payments for After Hours costs (offset by Other Revenue) – bring back a more fulsome result to explain the detail that sits behind this.</td>
<td>27 June</td>
<td>Margaret White</td>
<td>Included in Item 4.1 on today’s agenda.</td>
<td>✓</td>
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<tr>
<td>4 April 2018</td>
<td>Health and Safety Report</td>
<td>Elizabeth Jeffs to work with Health &amp; Safety to achieve a target of 100% for H&amp;S Orientation and Workplace Inspections. Vaccinations before Staff Start - it is currently not a pre-requisite to employment that new starters are vaccinated. At the moment, 1 in 6 people starting may not have some of the vaccinations required. This is an issue that the</td>
<td>27 June</td>
<td>Elizabeth Jeffs</td>
<td>Included in Item 3.2 on today’s agenda.</td>
<td>✓</td>
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<td>28 February 2018</td>
<td>Health and Safety Report</td>
<td>OHSS team recently raised and will work with Infection Control and the Chief Medical Officer to understand the complexities and see if this is something the DHB should be actively pursuing to ensure the organisation’s requirements, in terms of vaccinations, are being met. A progress update is to be included in the Health &amp; Safety Performance Report each month on how this is progressing.</td>
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<td>31 January 2018 (transferred from HAC)</td>
<td>Provider Arm Performance Report</td>
<td>The HAC Committee asked Mr Balmer to invite the Middlemore Foundation to attend the 16 May Board meeting to provide an overview of how the Foundation supports the hospital and to discuss their new strategy and structure. A copy of the MMF Constitution to be provided at this time.</td>
<td>27 June/8 August</td>
<td>Phillip Balmer</td>
<td>Deferred to 8 August as MMF are awaiting a new Director to start next month.</td>
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<tr>
<td>6 December</td>
<td>Health and Safety Report</td>
<td>Way Finding – the Board asked that a review of the Middlemore campus is undertaken by a traffic/transport management expert.</td>
<td>27 June/8 August</td>
<td>Elizabeth Jeffs</td>
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<tr>
<td>6 December</td>
<td>CE Report</td>
<td>The Board asked for regular updates to show the reduction of harm as a result of the Alcohol Position Statement.</td>
<td>12 Dec</td>
<td>Doone Winnard</td>
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<td>25 October</td>
<td>Demonstration – E-Vitals</td>
<td>The Chair noted that the Board would schedule a ward visit to enable them to see how e-Vitals is working at the bedside.</td>
<td>19 Sept</td>
<td>Phillip Balmer</td>
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<td>25 October</td>
<td>Decision Item – CM Health Hospices</td>
<td>The Chair requested a reconciliation of all of the increases and all of the uptake of demographic uplift so that every time the Board considers something, it can understand fully what is really being given away.</td>
<td>27 June/8 August</td>
<td>Margaret White</td>
<td>Work in progress and will be reported back in full on 8 August.</td>
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<td>2 August</td>
<td>Health and Safety Report</td>
<td>Executive Health &amp; Safety Committee Minutes to be submitted to the Board six weekly for the Board’s information.</td>
<td>27 June</td>
<td>Elizabeth Jeffs</td>
<td>Included in Item 3.2 on today’s agenda.</td>
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Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee
Held on Wednesday, 11 April 2018 at 9.10am – 11.10am
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART II – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Rabin Rabindran (Board Chair)
Dr Ashraf Choudary
Dianne Glenn
Katrina Bungard
Apulu Reece Autagavaia
John Wong

ALSO PRESENT

Benedict Hefford (Director Primary, Community and Integrated Care)
Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer)
Margie Apa (Director, Population Health & Strategy and Acting GM, Maaori Health)
Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present at this meeting.

APOLOGIES

Apologies were received and accepted from George Ngatai, Gloria Johnson, Campbell Brebner and Margie Apa and Katrina Bungard for lateness and Colleen Brown for an early departure at 11am.

WELCOME

The Chair welcomed all those present to the meeting. Ms Brown advised that she would be asking that the timing of the Maaori Provider meeting be expedited.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest amendments were noted.
Mr Rabindran advised that he was no longer a member of Solid Energy.
1. **AGENDA ORDER AND TIMING**

The order of the items were changed due to poor weather and presenters still travelling to the meeting venue. The minutes were recorded according to the order in which items were presented.

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 21 February 2018.**

*Resolution (Moved: Colleen Brown/Seconded: John Wong)*

That the minutes of the Community and Public Health Advisory Committee meeting held on 29 November 2017 be approved.

*Carried*

2.2 **Action Items Register/Response to Action Items**

*Noted.*

Ms Brown and Mr Hefford to have an offline conversation in regard to what is to be kept on for 11 April agenda or deferred to 23 May agenda.

3. **PRESENTATIONS**

3.2 **Advanced Care Planning (Matt Hannant & Karen Long)**

A comprehensive overview/presentation was provided to CPHAC.

This included benefits, data and some historical information.

Current activities include:

- ACP working group developing implementation plan
- Advertising for 2 x Locality Facilitators to support primary care
- Collaborating with System Level Measure (SLM) working group
- Secondary Care Special Interest Group
- High risk anaesthetic clinic project
- Shared Care Planning
- Consumer engagement
- Quality improvement

Palliative Outcomes Initiative (POI) was bought to the attention of CPHAC.

- An Auckland wide approach to primary palliative care
- Patients are identified in the community who are nearing the end of life
- Aim of POI to build capacity, capability and confidence of GP and Residential Care providers in the identification and management of palliative need
- ACP taken in to consideration when developing patient palliative care plan

Ms Long advised CPHAC around some of the challenges faced, including: lack of systematic processes, provider centric development of IT tools rather than patient journey, cultural assumptions and capability of workforce.
It is hoped that in the future we will see more integrated advance care planning across the care continuum, patient/person driven initiation and planning, more support and education for having difficult conversations (staff and students), more resources available in multiple languages. It would also be beneficial to have one IT system.

CPHAC were interested to determine if it could be a made a contract requirement for facilities to increase the number of ACPs being completed. Hospice could be a specialist and expert provider and these discussions are currently being undertaken.

**Resolution**
Given that Advance Care Planning is a useful tool CPHAC would like to recommend that the Board pass a resolution stating that increased completion of ACPs is written into future contracts with Hospice and PHOs.

**Moved:** Katrina Bungard/Seconded: Dianne Glenn  
**Passed:** Unanimously

Important to consider community meetings where ACPs could be discussed and facilitators could be on hand to assist with the completing of plans. Council flats also need to be taken into consideration.

**Resolution**
CPHAC would like to recommend that the Board and Executive Level staff raise awareness by completing their own ACPs and make this information available via staff information channels.

**Moved:** Katrina Bungard/Seconded: Dianne Glenn  
**Passed:** Unanimously

CPHAC thanked Mr Hannant and Ms Long for the presentation and the important work they are undertaking.

4. **BRIEFING PAPERS**

4.2 **Q2 2017/18 Population Health Performance Report (Filipo Katavake-McGrath)**

The report was taken as read.

Mr Katavake-McGrath introduced Ms Alanna Soupen who has joined the Planning Team to cover the maternity vacancy of Ms Kitty McQuilken.

Mr Katavake-McGrath provided a comprehensive overview of the report, highlighting areas such as:
ASH skin infections in Pacific Island children; trending downward over the last two years, however still a large equity gap.
Immunisations of Maaori babies; still a pocket of difficult to reach mama and pepis.
Obese children; MOH is beginning to work on a measure for this group.

CPHAC were interested to know if all referred children took up the assistance offered, could all of the local services cope?

Mr Hefford advised CPHAC that in conjunction with Debbie Holdsworth, he has sent a letter to the Chief Health Advisor.
CPHAC encouraged Mr Hefford to request a combined regional CPHAC meeting be held and the MOH invited to address the concerns contained within Mr Hefford's letter. CPHAC would like to see a Senior MOH staff member be in attendance to address areas of critical concern across the region.

**Action**
Mr Hefford will forward the letter to Ms Brown to review questions.

Mr Katavake-McGrath advised the committee that in terms of Asian Health Ms Kitty Ko is working around appropriate Models of Care across Palliative and Primary Care, CVD and Long Term Conditions for Indian men and women and Cervical Screening for Indian/Asian women.

CM Health is attempting to widen the ethnic range of statistics that we can pull down from the MOH.

**Action**
CPHAC requested that the Asian Plan be at standing item, twice a year.
Ms Kitty Ko to present 23 May 2018.

**Action**
Mr Benedict Hefford and Ms Margie Apa to email Ms Colleen Brown in regard to Pacific ECE interaction and a potential loss of resource.

**Action**
Mr Filipo Katavake-McGrath to provide a verbal update to CPHAC re Q3 Reporting on 23 May 2018.

### 4.1 Primary & Community Nursing Workforce Update (Karyn Sangster)

There are many nursing roles across the primary and community workforce. The numbers of nurses working across the region has remained relatively static. In 2006 the total primary care nursing workforce was 349 FTE in 2015 when asked to provide a comparison Primary Health Organizations nurse leaders identified 371 nurses working in primary care. The growth in the number of practice nursing roles has not increased greatly compared to the growth in the population. Public health nurses have reduced from 40 to 28 with other contracts now providing basic nursing in high decile schools. The district nursing FTE was 43 in 2006 and 48 in 2015 a small increase and about 1 or less DN FTE for every 10,000 people in our district.

The long term investment plan for the Northern regions states that the anticipated demand for health care for our growing, aging and changing population will outstrip our ability to deliver services. A more agile and flexible workforce with capability and diversity to meet the care health needs of our local population will be needed. This change is needed now by strengthening collaboration and integration across the care continuum to provide care closer to home. We need to reshape the workforce to provide innovative integrated models of care that can to respond to our changing population needs. Nurses will need to expand and advance their clinical practice across our current workforce including unregulated carers. This will allow our professional workforce to reach more people through directing and delegating care tasks to skilled others.

This will be supported by key enablers such as technology, education, inter-professional practice, community central providing central coordination of requests for service, and integration to allow nurses to respond to the workforce and population challenges. As these continue to develop we will explore new ways of providing care within the community using existing and new workforces.
The funding of new roles and models of care remains uncertain with the review of primary care funding and DHB budgets. The funding remains uncertain as we are challenged to provide more with the existing workforce. The profession continues to respond to support more advanced nursing practice through prescribing scopes and post graduate nursing programs.

With regard to Plunket Nurses, these roles are:
- Funded centrally so CM Health have no say.
- Have a good working relationship with CM Health Alliance.
- Have joint roles with CM Health and Oranga Tamariki.
- Have 55 cars on the road every day.
- Are open to working differently.
- Targets and contacts are central.
- Undertake B4 School Checks and work Saturday’s at Manukau Super Clinic.

SIB Funded Home Visit Nurses
The establishment of the social investment board has enabled a new service focussing on supporting young mothers in Mangere with a well-child and child health mixed role with integrated with social workers. The service has developed guidelines and is now recruiting the final staff members. The vision is to provide a well-child service with a keeping well context supporting and navigating young families through the health and social services. This includes a multi-agency team working with a family for an extended length of time.

Action
CPHAC felt that this was appropriate for some ‘good news media’. Mr Hefford is to advise Ms Donna Baker (Communications Manager) that CPHAC are looking for some good news stories.

Action
Ms Jenny Parr and Ms Karyn Sangster to please email nurses on behalf of CPHAC expressing their thanks and appreciation.

There was a suggestion that Board members undertake the Patient Safety Leadership Walks with Ms Parr coordinating the Board members.
Ms Parr suggested at CPHAC visit to Community Central to view their base of operations.

Action
CPHAC to commence meeting on 23 May 2018 at Community Central for a half hour look at their operations.

Ms Dianne Glenn advised that she will be attending the Leadership Round at Pukekohe.

CPHAC would like to see the Walkaround Plan. Could think about training for Board members prior to walking in the wards.

CPHAC thanked Ms Sangster for the informative presentation.

Ms Brown departed the meeting at 11am.
3.1 Manukau Locality Update (Sarah Marshall)

Ms Marshall provided a comprehensive update on activities within the Manukau Locality.

Highlights included:

**Strengthening Primary Prevention**
- Family Hauora Event – Kaye Dennison and three School of Population Health students had an access affordable to Health Care/Immunization stand at this event.
- Clendon Community House – Three final year Nursing students (Auckland University) will complete a project with the Manager and volunteers at Clendon Community House in developing a Hauora Tool kit for this facility.
- Clendon Pride Hauora Market – This will take place before a Bilingual Hiko on 14th April. Four School of Population Health students are supporting this event on the day – 25 health promotion stands have registered.
- Immunisation Project – Four School of Population Health students are completing a project (1 semester) on identifying reasons for the decrease in immunisation rates in Manukau, through focus groups with health providers and a range of ethnic specific community groups.
- Alcohol Harm Minimisation Project – This research project is being run in collaboration with Family Start Manukau, two groups of social workers are being trained in assessments related to alcohol harm and appropriate brief interventions. The project will run for nine months.

**Strengthening Secondary Prevention**
- Complex Case Managers are supporting General Practice Teams.
- Rawiri Community House – Manukau Locality will continue to support health initiatives (through linking in health and social service agencies as required) for the Homeless in Manurewa, through the Manager of Rawiri Community House.
- Counties Manukau Kindergarten Association – Manukau Locality continues to work collaboratively with the Kindergarten Association and in particular, the Play truck coordinators who work closely with vulnerable families in high deprivation areas and have the opportunity to share health promotion messages as part of their service delivery.
- Hydrotherapy opportunities for severely disabled people. Manukau Locality, as part of the locality wellness work, is supporting a swimming instructor to get access to heated public swimming pools, to support these individuals.

**Strengthening Tertiary Prevention**
- Manukau Locality Community Heath Team is being introduced on a monthly basis to a range of Health and Social service providers working in the areas who can take referrals from the District Nurses and Alliance Health team to support integrated care e.g. Age Concern, WINZ, Habitat for Humanity Home Repairs service.

CPHAC were interested to determine if CM Health is well resourced in the area of Community Networks. Ms Marshall advised that Papatoetoe Community Network had little community support and was at risk of stopping altogether. Given this is a key community group for Manukau Locality to engage with the Project Manager for the Locality has taken on a shared role in coordinating the network meeting for this current year, with a view to stepping down once the network is in a better state and new coordinators can be identified. Health messages are shared at each meeting. The Manurewa and Papakura Community Networks held monthly meetings that large numbers of people attend and have good forums for health promotion and consultation.
Ms Marshall was asked if CM Health link with the Life Education trust and Ms Marshall advised that she would follow up with Kaye Dennison.

The meeting concluded at 11.10am.


______________________________

Colleen Brown
Committee Chair
Counties Manukau District Health Board  
Chief Executive’s Report

Recommendation

It is recommended that the Board:

Receive the Chief Executive’s Report.

Prepared and submitted by: Gloria Johnson, Acting Chief Executive.

Since the last Board meeting we have commenced regular meetings with Ministry of Health officials as part of our Intensive Monitoring status. These meetings enable us to share data, develop a shared understanding of what it means and discuss options for responding to our financial and demand challenges. To date our team has been finding the meetings very valuable and hopefully as they continue they will assist us to develop plans which have mutual endorsement.

The inset of colder weather has seen a recent increase in presentations to the Emergency Department, which is likely to be sustained now until the winter season with its associated medical illnesses, especially respiratory conditions, is over. We have shifted in to a winter bed pattern which switched some surgical beds to medicine and are prepared to open additional beds if necessary.

News and Events Summary

Nursing, Midwifery, Allied Health, Scientific and Technical Professions and Patient Experience Leadership Restructure

The Nursing, Midwifery and Allied Health, Scientific and Technical workforce at CM Health accounts for just over 65% (4671/6951) of our staff, so the leadership, workforce development and skill of that very large, diverse group is vital to our success.

The structure which was currently in place with these workforces was not wrong or broken - however, the question for me has been, what structure would be optimal for CM Health to get the best from these workforces at this point in time. Our challenges remain significant. Our financial and facilities challenges are well known but we should not ever forget that our real challenges lie in the ever-increasing needs of the population we serve and that our workforce is our greatest asset in meeting those challenges.

In light of the feedback received during the consultation phase, the following key decisions have been made:

1. The role Director of Patient Care, Chief Nurse and Allied Health Professions Officer be spilt into two Executive Leadership Team positions:
   1. Chief Nurse/Director of Patient and Whaanau Experience; and
   2. Chief Allied Health, Scientific and Technical Professions Officer

   This means that the current role of Director Allied Health will be disestablished (the substantive role is currently filled with an Acting Director so there is no redundancy).

2. The role of Chief Nurse/Director Patient and Whaanau Experience will continue to be accountable for leadership of the Nursing and Midwifery workforces and the delivery of a programme of work to continuously improve Patient and Whaanau Experience, retaining organisation-wide responsibility, along with other ELT members, for patient safety, standards, measurement, certification and patient experience. The incumbent Director of Patient Care, Chief Nurse and Allied Health Professions Officer will assume this role. It was noted in feedback that a strong voice for Midwifery at the executive level was important but that, under current legislation, this could not be reflected in the job title unless the
incumbent were a practising midwife. The Director of Midwifery will continue to report to the Chief Nurse/Director Patient and Whaanau Experience, who will be responsible for ensuring that Midwifery is strongly represented at the executive level.

3. A Deputy Chief Nurse role will be established, with system-wide influence and nursing leadership with capacity to support CNDs. This means that the current role of Director of Nursing – Hospital will be disestablished (the substantive role is currently vacant so there is no redundancy).

4. The CND Mental Health & Addictions will report to the Chief Nurse, given the wide breadth and impact of this particular CND role.

5. The Clinical Training and Education (CTEC) Manager will report to the People and Professional Development Lead but will meet at least quarterly with the Chief Nurse/Director of Patient and Whaanau Experience to consider strategic issues in relation to the team and its role.

6. A Patient Experience Lead will be established, reporting to the Chief Nurse/Director Patient and Whaanau Experience. This new role will be advertised internally, with preference given to redeployment options.

7. The Patient and Whanau Adviser role will be renamed Engagement and Experience Adviser and will report to the Patient Experience Lead.

8. There will be no change to the reporting line of the Patient Safety Manager, this role continuing to report to the Chief Nurse/Director Patient and Whaanau Experience.

9. The Quality Assurance Manager role will be disestablished as its key functions will be subsumed under the new role of Patient Experience Lead. Redeployment options will be considered for the incumbent.

10. The Volunteer Coordinator will report to the Patient Experience Lead.

The new structure is likely to be implemented by 1 August 2018.

**United Nations Indigenous Forum Update**

A group of young Maaori leaders from Counties Manukau were part of an official delegation to the United Nations Indigenous Forum in New York in April 2018. Members of the delegation presented at the Forum about constitutional reforms, environment, indigenous knowledge, and health and wellbeing.

In supporting our rangatahi (youth) to attend the Forum, the Maaori Health team at CM Health aimed to build the capability of rangatahi to advocate for Maaori health issues in Counties Manukau on an international stage, and expose young Maaori from Counties Manukau to leaders at the highest levels of governance.

Since returning from the UN, a follow-up event (Moko Foundation Youth Leadership Summit) has taken place in Counties Manukau to report back on the delegation’s findings and to mobilize and inspire other young Maaori in South Auckland.
**Future Focus**

**Cutting Emissions in Healthcare**

In late November 2017 a small group of people at Middlemore Hospital celebrated a remarkable achievement – a reduction in the carbon footprint of Counties Manukau DHB by 21.2% in just 5 years.

That work which began in 2011 was fuelled by the good will of a small group of ordinary people: doctors, nurses and others who took it upon themselves to take action on Climate Change by doing the same simple things at work that so many were already doing at home; conversations about small stuff in the main, recycling and reducing waste, then a growing desire to learn more about our own carbon footprint and the relationship between Climate Change and healthcare more generally.

Waste, energy and transport make up only 30% of a healthcare system’s carbon footprint, over 60% is related to procurement or more specifically to the life cycle costs of the medicines and the myriad of bits of equipment and devices we use in everyday practice. So, the purchase cost of those items should take into account the Carbon cost of each item’s manufacture, packaging, transport, use and disposal. This approach opens up a raft of new opportunities to do things differently, e.g. the chance to reassess the benefits of using multi use instead of single use instruments to decrease overall costs and improve value.

Our story is a simple one that started with a small group of committed people, a goal, a method and with measures to guide progress. The gains made to date are there for all to see and now 6 years on we can clearly see the way forward, for us in healthcare and indeed for the public sector at large.

**Improved equity in access to timely cancer treatment**

An audit of patients entering the Faster Cancer Treatment 62-day pathway over the 12-month period 1 Feb 2015 - 31 Jan 2016 found that Maori and Pacific patients, along with those living in the highest areas of socioeconomic deprivation, were significantly less likely to meet the 62-day target than their counterparts. A series of interventions were developed to address this inequity. We raised the profile and awareness of our population-based Cancer Nurse Coordinators for Pacifica and Maaori patients, ensuring that patients were referred to them early in the pathway and not only when problems occurred. In addition we developed reports notifying staff of patients who identify as Maori and Pacific within 24 hours of them being graded as high suspicion for cancer. This promoted increased engagement in services, and better support for these high needs populations. Performance data for patients that went on to receive treatment
was broken down by treatment type and ethnicity and used to measure against the 62 day FCT Health Target and the 31 day priority indicator so that progress could be monitored.

A more recent audit covering the 12 months between 1 Nov 2016 - 31 Oct 2017 has found ethnicity and level of deprivation is no longer associated with passing the target. This means that Māori, Pacific, and those patients living in the most deprived areas are just as likely to meet the 62-day Faster cancer Treatment Health Target as European/Other patients, and those living in the least deprived areas. The findings from this recent audit have demonstrated that the efforts to achieve equity through developing standardised pathways for patients and improving care coordination for these vulnerable patient groups has been working at CM Health. This outcome is significant. It indicates that the sustained focus on reducing disparities in health for more vulnerable groups referred with a high suspicion of cancer has made a tangible difference.

The number of tumour streams less likely to meet the target has also reduced from 6 in the original audit period to 2 tumour streams, reflecting improved care processes overall.
## Performance and Outcomes Priorities

### Health Target Summary – 2017/18

<table>
<thead>
<tr>
<th>Target</th>
<th>Current Results</th>
<th>Status by 30 June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Departments</strong></td>
<td><strong>95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</strong>&lt;br&gt;<strong>March 2018 (Q3 result):</strong> 90% (target 95%)**&lt;br&gt;<strong>Note:</strong> Patient volume and bed demand pressures mean that the hospital has been unable to reach the six-hour target; achieving 90% for March against a target of 95%. This is due to a variety of factors, high consistent surge presentation rates and consistently high hospital occupancy.</td>
<td>AT RISK</td>
</tr>
<tr>
<td><strong>Elective Surgery</strong></td>
<td>Elective surgery will increase by an average of 4,000 discharges per year&lt;br&gt;<strong>March 2018 (Q3 result):</strong> 98.7% (target 100%)&lt;br&gt;<strong>ESPI results for Q3:</strong>&lt;br&gt;ESPI2: 204 FSA breaches (1.9%) (target &lt;0.2%)&lt;br&gt;ESPI5: 126 treatment breaches (3.8%) (target &lt;0.9%)&lt;br&gt;<strong>Note:</strong> Due to sustained high acute volumes and anaesthetists shortage, there is continued pressure on both ESPI 2 (FSAs) and ESPI 5 (Treatment) in a number of services. We have received REDs in March 2018. We have a strong plan in place to recover our elective volumes.</td>
<td>AT RISK</td>
</tr>
<tr>
<td><strong>Faster Cancer Treatment</strong></td>
<td><strong>90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.</strong>&lt;br&gt;<strong>March 2018 (Q3 result):</strong> 95% (target 90%)&lt;br&gt;<strong>Note:</strong> As of 1 July 2017, the target has increased from 85% to 90%; however, the definition at this time has also changed. Under the new target definition, only those relating to capacity constraints are counted as breaches. 100% reported, excluding patient choice and clinical consideration breaches (23/23 patients). 72% overall, including all breaches (23/32 patients). Of the 9 breaches: 5 were patient choice; 4 were clinical consideration.</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td><strong>Immunisation</strong></td>
<td><strong>95% of eight month olds will have had their primary course of immunisation on time (and significant progress has been made towards the target for the Maaori and Pacific population groups).</strong>&lt;br&gt;<strong>March 2018 (Q3 result):</strong> 93% for total population (Maaori coverage: 86%, Pacific coverage: 93%) (target 95%)&lt;br&gt;<strong>Note:</strong> To achieve the overall target for Q3, 33 more babies would have had to be immunised. Maaori immunisation rates have dropped from 89% in Q1 to 86% in Q3.</td>
<td>AT RISK</td>
</tr>
<tr>
<td><strong>Raising Healthy Kids</strong></td>
<td><strong>95% of obese children identified in the Before School Check (B4SC) Programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions</strong>&lt;br&gt;<strong>March 2018 (Q3 result):</strong> 100% total population (Maaori: 100%, Pacific: 100%) (target 95%)</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td><strong>Tobacco Primary</strong></td>
<td><strong>90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months</strong>&lt;br&gt;<strong>March 2018 (Q3 result):</strong> 90% total population (Maaori: 89%, Pacific: 89%) (target 90%)</td>
<td>ACHIEVED</td>
</tr>
</tbody>
</table>
Maternity

90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

March 2018 (Q3 result): 91% (Maaori 90%, Pacific: not reported) (target 90%)

ACHIEVED: Already meeting target / will meet target by 30 June 2018.
ON COURSE: Expected to meet target by 30 June 2018.
AT RISK: Risk that target will not be met by 30 June 2018 unless performance improves.

* Performance against the Elective Surgery target is reported one month in arrears.
** Data provided from the MOH quarterly (for previous 6 months). Result reflects percentage of children identified as obese for whom a referral has been sent and that referral has been acknowledged.
Counties Manukau District Health Board
Occupational Health and Safety Performance Report

Recommendation

It is recommended that the Board:

**Receive** the Health and Safety report for the period ending 31 May 2018.

Purpose

The purpose of the Health and Safety (H&S) report is to provide monthly reporting of health, safety and wellbeing performance including compliance, indicators, issues and risks to the Counties Manukau District Health Board.

Executive Summary

There were no notifiable events in May.

The 2018 Flu Vaccine Campaign continues with a completion rate of 64% to 31 May 2018 (National target 80%). There has been a substantial increase in the total number of people vaccinated year on year.

The number of injury claims reduced during this period primarily due to decrease in slips, trips and falls and the ACC system error backlog.

Key risk programmes in support of improving management of:

- Aggression and Violence in ED. Research Paper attached and further work to capture low level verbal abuse and violence has been initiated by the service to further understand the type and total number of events happening.
- Wellness. New online portal launched to enable easier access to initiatives.

Current Issues Update

Bullying, harassment and discrimination

In April the DHB released data showing the number of bullying complaints made in the last five years and it was reported that Counties Manukau Health had the highest number of complaints of the three Auckland DHBs. There are a number of factors which will be contributing to this:

1. The Human Resources Team have been excellent at recording any issue raised with them even if the matter did not then translate into a formal complaint being pursued.
2. The Human Resources Team use the same set of data to record enquiries and complaints. It is now too complex to extract out the contact with HR which was an enquiry and rather than a formal complaint.
3. In recent years with the refresh of the Values and the introduction of Pastoral Care and Supporters Group as part of a “Speak Up” campaign, people were asked to raise issue and report any matter of the concern to them. There has not been increase in the number of disciplinary outcomes.

In May the DBH took the opportunity to of the Mental Health Foundation ‘Pink Shirt’ day to encourage staff to report issues relating to bullying, harassment and discrimination. Many parts to the organisation “went pink” for the day.
Violence in ED topical issue in paper and research paper
Attached as an appendix is a copy of a research project completed at Counties Manukau about the reporting of incidents of Violence and Aggression in ED. Similar work was completed at another DHB and received some publicity.

CMH ED is running a pilot to identify all incidents, including near miss incidents to understand and address issues, aligned with ‘Speak up’ campaign.

ACC AEP Audit preparation (November 2018)
The ACC Audit is due in November. The DHB has tertiary accreditation. The DHB is completing a self-audit to identify its current compliance. It should be noted that there is now a higher threshold aligned with HSWA 2015. An Injury Management reviewed in 2017 retained tertiary accreditation and noted the high standards at the DHB for Injury management. A report will be submitted to the ELT in July outlining gap against tertiary level with recommendations for projects, resourcing with expectations for audit results.
## Performance Scorecard

### Health and Safety Scorecard

**May 2018**

#### Lagging Indicators

<table>
<thead>
<tr>
<th>Number of Reported Incidents</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>131</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Contractors</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Visitor</td>
<td>2</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

| Number of Injury Claims      | 18     | <35    |       |
| Lost time incidents          | 3      | <5     |       |
| Lost time injury frequency rate | 8.16  | <5     |       |
| Cost of Injury claims        | $5,000 | -      |       |
| Lost time injury severity rate | 109.53 | <530   |       |

#### Leading Indicators

<table>
<thead>
<tr>
<th>Achievement Criteria</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>On target or better</td>
<td>Achieved</td>
</tr>
<tr>
<td>95-99.9%</td>
<td>Substantially achieved</td>
</tr>
<tr>
<td>90-94.9%</td>
<td>Not achieved, but progress made</td>
</tr>
<tr>
<td>&lt;90%</td>
<td>Not achieved</td>
</tr>
</tbody>
</table>

#### Comment on Variations

<table>
<thead>
<tr>
<th>Indicators in Red</th>
<th>Comment</th>
</tr>
</thead>
</table>
| H&S Representative Training | • Annual target at 89.5% of 100% target.  
• A total of 138 H&S Reps have completed their training  
• Training will cease during winter months and start again in Spring. |

<table>
<thead>
<tr>
<th>Staff flu vaccination uptake</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>As at 31 May 64% vaccinated.</td>
<td></td>
</tr>
</tbody>
</table>
First phase campaign finished at end of May with ongoing vaccination programme through service peer support, OHN and Middlemore Central. |

<table>
<thead>
<tr>
<th>Indicators in Blue</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Pre-employment health screening completed | • Winter campaign and bulk recruitment resulted in increase of PEHS.  
• 95 of the 96 new employees that commenced in May had full clearance prior to their start date.  
• 1 casual staff member commenced employment without a completed PEHS. |
INJURY CLAIM DATA

Total: Injury Claim Report for May 2018

<table>
<thead>
<tr>
<th>Number of lost days for month</th>
<th>Lost days</th>
<th>Treatment cost</th>
<th>Weekly compensation costs (80% of salary)</th>
<th>Staff cover cost</th>
<th>Total $ cost for month</th>
</tr>
</thead>
<tbody>
<tr>
<td>149.20</td>
<td>149.20</td>
<td>46,265.56</td>
<td>16,709.92</td>
<td>24,238.15</td>
<td>87,213.63</td>
</tr>
</tbody>
</table>

Key Health and Safety Risks

The table below outlines key health and safety risks together with commentary on the status/issues related to that risk and remedial actions have been taken:

<table>
<thead>
<tr>
<th>Key</th>
<th>Risk is well managed – all significant actions complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk is well managed - some minor actions to be completed</td>
<td></td>
</tr>
<tr>
<td>Risk is being managed and has some significant actions underway</td>
<td></td>
</tr>
<tr>
<td>Risk is being managed and has some significant actions yet to progress</td>
<td></td>
</tr>
</tbody>
</table>

**Risk: Occupational Health and Safety - Aggression and Violence**

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Finalise scoping of ‘deep dive’ governance audit on Emergency Department, Mental Health and Community.</td>
<td>• Consider how best to complete a deep dive on this topic.</td>
</tr>
<tr>
<td>• Health Alliance trialling second application.</td>
<td>• New pilot showing stronger economic feasibility.</td>
</tr>
<tr>
<td>• Community reviewed WDHB policy and guidelines, current work to be aligned and incorporate feedback from services.</td>
<td>• Review of WDHB policy and guidelines still on going.</td>
</tr>
<tr>
<td>• RiskPro upgrade.</td>
<td>• ED piloting separate system to capture incidents with H&amp;S to report on trends in June.</td>
</tr>
<tr>
<td>• Feedback on dedicated security in ED positive for staff and patients.</td>
<td></td>
</tr>
</tbody>
</table>

**Risk: Occupational Health and Safety - Community Health Work**

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The use of electronic calendars for all appointments is nearly complete.</td>
<td>• Review of effectiveness of use of electronic calendars. Connectivity with personal alarm system/software will enable better tracking.</td>
</tr>
<tr>
<td>• Training sessions for lone workers are part of the Building Capability calendar.</td>
<td>• Lone worker training continuing.</td>
</tr>
<tr>
<td>• Buddy system for all new people – check in during the day and at the end of day.</td>
<td>• Trial of new personal protection unit/software continuing within the services.</td>
</tr>
<tr>
<td>• Lone worker app – GPS tracking with panic button.</td>
<td></td>
</tr>
<tr>
<td>• Community Central process for checking files and data underway.</td>
<td></td>
</tr>
</tbody>
</table>
## Risk: Blood and Body Fluid Exposure (BBFE)

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No update since last reporting period.</td>
<td>• No further update in May.</td>
</tr>
<tr>
<td>• Reduction in BBFE incidents following continued briefing of clinical and cleaning staff of risks of incorrect disposal of needles.</td>
<td>• Increase in BBFE incidents reported due to new intake of nursing and Junior Doctors.</td>
</tr>
</tbody>
</table>

## Risk: Hazardous Substances and New Organisms (HSNO)

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Facilities/Maintenance and need to follow up on close out plan for action points.</td>
<td>• No further update since last reporting period.</td>
</tr>
<tr>
<td>• Hazard Registers on site to be updated following above actions and regular reviews to ensure continued compliance.</td>
<td></td>
</tr>
</tbody>
</table>

## Risk: Occupational Health and Safety - Safe Moving and Manual Handling

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Steering Group meeting.</td>
<td>• Steering group meeting and 3 work groups updating on progress against project deadlines on track.</td>
</tr>
<tr>
<td>• 3 work groups set up with their scope of work defined and work plans in place.</td>
<td>• Increase in M&amp;H injury reporting as result of TROPHI tool roll out to other services.</td>
</tr>
<tr>
<td>• Resourcing being reviewed for project implementation rollout.</td>
<td>• Draft implementation plan to be presented to ELT in June.</td>
</tr>
<tr>
<td>• Draft implementation plan to be presented to ELT.</td>
<td></td>
</tr>
</tbody>
</table>

## Risk: Compliance - Contractor Management and Procurement Management

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Scope finalised for contractor management and to be reviewed.</td>
<td>• Contractor project plan to be implemented.</td>
</tr>
<tr>
<td>• Reviewing WDHB contractor management pre-engagement online process.</td>
<td>• H&amp;S monitoring major works projects underway KA2 and Tiaho Mia.</td>
</tr>
<tr>
<td></td>
<td>• H&amp;S/F&amp;E working on Scott re-clad project plan.</td>
</tr>
</tbody>
</table>

## Risk: Compliance - Health & Safety Training Framework

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New: OHSS/KA collaborating in development of a multi-tier H&amp;S orientation for new employees at CM Health. Based on WDHB’s online tool in combination with monthly touch-points over the employee’s first 3 months at CM Health.</td>
<td>• Progress on development of H&amp;S orientation on track.</td>
</tr>
<tr>
<td>• New: Review of 2-day H&amp;S Rep training to reduce to 1 day.</td>
<td>• H&amp;S Induction training reworked to cover fewer areas and include Manager/H&amp;S Rep in follow up in service.</td>
</tr>
<tr>
<td></td>
<td>• H&amp;S Rep training to be delivered via an external resource from August due to resignation of accredited trainer.</td>
</tr>
</tbody>
</table>
### Risk: Occupational Health and Safety - Slips, Trips and Falls

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New: refresher training presented to the CM Health Cleaning teams around wet/slippery floors, housekeeping and other areas where a slip/trip/fall hazard may occur.</td>
<td>• No further update.</td>
</tr>
</tbody>
</table>

### Risk: Wellness – Employee Health and Wellbeing Programme (stress, fatigue, depression)

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PMO developed timeframe tool on Daptiv with project actions.</td>
<td>• Daptiv project action plan on track.</td>
</tr>
<tr>
<td>• Flu Vaccination programme ready for rollout, still require project plan for capturing framework.</td>
<td>• Flu vaccination programme phase 67%</td>
</tr>
<tr>
<td>• EAP programme for OHSS/H&amp;R framework approved and ready for rollout in April.</td>
<td>• Flu vaccination programme flow chart/process to be documented for next year.</td>
</tr>
<tr>
<td>• “Speak Up” campaign progressing with stakeholder engagement and project plan for rollout in May.</td>
<td>• Speak up campaign launched with communication plan and rollout to all of business including unions.</td>
</tr>
<tr>
<td>• Organisational Development Manager developing a “wellbeing” strategy in collaboration with Waitemata and Auckland DHBs.</td>
<td>• OD Manager part of working group to look at Regional ‘wellbeing’ strategy.</td>
</tr>
<tr>
<td>• Preparation for launch of the National GM HR Wellbeing website underway.</td>
<td>• GM HR wellbeing website launched.</td>
</tr>
</tbody>
</table>

### Risk: Physical environment (ventilation, lighting, noise, equipment)

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review of incorporating Environmental elements into hazard checklist to continually audit and identify improvements.</td>
<td>• Draft checklist prepared and reviewing with online hazard walkthrough model to monitoring environmental aspects to be referred to F&amp;E.</td>
</tr>
<tr>
<td>• Investigating collaboration between CM Health Facilities &amp; Engineering Service monitoring/auditing processes to align process for CMH and services.</td>
<td>• Health monitoring plan for staff identified as being exposed to environmental hazards.</td>
</tr>
<tr>
<td></td>
<td>• Surveys of buildings complete and an Asbestos Management Plan draft produced by F&amp;E for review.</td>
</tr>
</tbody>
</table>

### Risk: Compliance - Worker Participation

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New: H&amp;S Rep training feedback reviewed, with positive feedback from internal and external stakeholders on quality of training CM Health providing.</td>
<td>• Health and Safety Rep training completed in May with June/July cancelled recognising occupation rate in hospital.</td>
</tr>
<tr>
<td>• National Participation Forum: awaiting update on Union feedback on proposed Worker Participation across all DHB’s.</td>
<td>• National Participation: still awaiting update on Union feedback.</td>
</tr>
<tr>
<td>• The Health and Safety team hosted the first Health and Safety Hub for Reps, Champions and Managers – there were 23 attendees.</td>
<td>• Review of H&amp;S Orientation Day with presentation aligned with new online tool and co-facilitation with H&amp;S Rep to explain in service H&amp;S Rep role.</td>
</tr>
</tbody>
</table>
Reported Incidents

**Rolling year-on-year monthly average comparison:**

Previous 13 months – 106  
Current 13 months – 114.2

**Environmental factors:** no acute injury impact with issues as included in ‘Other’ category:

- excessive noise
- glare
- cleanliness
- temperature
- damaged property
- blocked/obscured entrances
- trespass

Given the ‘Other’ category is at 36 being the highest, herewith the causation profile:

- laceration/cut/tear: 10
- crushed/pushed/stepped on: 6
- Hitting stationary/ moving object: 6
- bite/sting – insect/spider: 5
- burn/scald: 3
- theft – actual/alleged: 2
- cleanliness of facility: 1
- failure to obtain appropriate assistance: 1
- obstructed entrance/exit: 1
- property damage: 1

**Key Observations:**

- 139 incidents reported in May 2018 consistent with May 2017.
- SAP reporting the highest at 32. Due to the New Grad Nurses intake May 2018.

**Notifiable Events**

<table>
<thead>
<tr>
<th>Date Reported to WSNZ</th>
<th>Type of Incident</th>
<th>Injury Sustained</th>
<th>Date of Incident</th>
<th>Outcome Recommendations Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>No notifiable events in May 2018</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Predominant Incident Profile

The incident profile consists of the following top four injury types for May 2018 including all employee, visitor and contractor incidents:

- BBFE: 34
- Aggression and Violence: 23
- Moving and Handling: 17
- Slip, Trip and Falls: 16

The number of reported incidents increased from 125 in April to 139 in May attributed to an increase in BBFE figures and additional new nursing and RMO’s.

Key reasons:
- Body Blood Fluid Exposures – increase in reported incidents with new graduate nurses/RMO’s.
- Aggression and Violence – decrease in reported incidents, although separate ED programme being tracked which may impact numbers.
- Moving and Handling – have decreased, following increase over the last period following TROPHI pilot.
- Slip, Trip and Falls – increase in reported incidents, as hospital busier and winter weather impacts.
- The balance of incidents is mainly defined as ‘Other’. These relate to minor incidents such as insect bites and contact with static objects.

All incidents have been followed up with the manager of the area to investigate and incident close off.

**BBFE (Blood or Body Fluid Exposure)**

### Rolling year-on-year monthly average comparison:

- Previous 13 months – 22.5
- Current 13 months – 23.5

- Increase in the number of BBFE incidents compared to May 2017. 34 BBFE incidents in May, of which 20 occurred in Nursing/Midwifery due to new intake of graduate nursing staff.
- BBFE notifications are followed up and tracked by the OHSS clinical team together with follow up screening/treatment. The work area managers are contacted to ensure process improvement.

### Causation profile:

- Inattention/Distraction: 12
- Other: 6
- Acts of others: 4
- Patient Condition: 4
- Policy/Safety Rule Violation: 4
- Fatigue/ tiredness: 1
- Incorrect Work Techniques: 1
- Job factor: 1
- PPE not used: 1

![Graph showing 25 months BBFE incidents reported](image)

![Graph showing BBFE incidents by Division May 2018](image)
**Aggression and Violence**

### Rolling year-on-year monthly average comparison:

- Previous 13 months – 21.1
- Current 13 months – 26.3

- Decrease in the reported aggression and violence incidents compared to the previous reporting period (April), due to ED running pilot on increasing reporting on incidents/near misses captured on spreadsheet to be migrated to Riskpro.
- Security team have a presence in the ED, which has resulted in some change in behaviour.
- Incidents remain highest in Mental Health.

**Causation Profile:**

- Assault – Physical: 10
- Behaviour – Aggressive/Violent: 7
- Behaviour – Inappropriate: 3
- Assault – Verbal: 3

### Moving and Handling

#### Rolling year-on-year monthly average comparison:

- Previous 13 months – 20.5
- Current 13 months – 19

- Moving and Handling incidents fluctuated with a significant increase in April as a result of the TROPI tool rollout. Impacted with ACC software issue and backlog of incident referrals. The reported incidents for May 2018 are lower compared to May 2017.
- Incidents remain highest in Mental Health.

**Causation profile:**

- Awkward posture/ equipment malfunction/ job factors/ action/ behaviour of employee or patient/ affiliate, human factors: 11
- Assistance unavailable: 2
- Lifting /carrying/load size: 2
- Repetitive handling/ movement: 2
- Sustained position/ posture: 1
Slips, Trips and Falls

Rolling year-on-year monthly average comparison:

Previous 13 months – 13.3
Current 13 months – 13.1

Slips, Trips and Fall incidents are consistent for the rolling year and compared to May 2017.

Initiative to reduce slips, trips and falls with the cleaning staff to encourage awareness of hazards and to encourage near miss reporting.

Causation profile:

Fall: 15
Fell from standing position: 1

Reported Incidents Summarised by Workforce and Division
Workplace Inspections

The Workplace Inspection programme identified as the key process to identify, track and implement a continuous improvement programme for our service areas.

The H&S Reps conduct workplace inspections in their area bi-monthly, to ensure that the hazard controls are in place, work effectively and are monitored within the service and updated with new or temporary hazards.

The workplace inspection checklists are completed by the H&S representative in conjunction with the Service manager/team leader. The checklist provides action points for review and close off.

The final completion figure for the March/April 2018 workplace inspections was 98%.

The H&S team are continuing to work with the Facilities Team to ensure that:

- Issues identified within the Workplace Inspection relating to Engineering and Facilities maintenance is reported for action.
- Repair requests are completed and closed out e.g. broken equipment removed or replaced.
- Draft Facilities and Maintenance and H&S Workplace inspection tool is finalised and will sit within an Audit framework to be completed in next two-month period.

The next inspections are due to be completed during June 2018 and will be reported in the next report period.

Occupational Health Service

2018 Flu Campaign

As at 31 May 2018, 64% of the CMDHB staff received flu vaccinations and the programme is continuing in the service areas through the 130 peer vaccinators and supplemented with the OHN team.

OCC Service Activity for May 2018

Case and Claims Management:

Current Claims referred to as low and high risk claims that are currently being managed by OHSS.

Pending Claims, taking into account the New Claims which require Initial Assessments and further investigation before a cover decision is made.

Theoretically a new complex claim may be pending for 21 days before all evidence is gathered and the employee is booked to see an OHP for review and recommendation to either Accept/Decline.
Vaccinations

Vaccinations:
Vaccination programmes for pre-employment screening have increased and in addition 53 flu vaccines were administered in the clinic in May 2018.

Occupational Health Nurse staff have been involved in flu vaccinations and filling out the roster for the Independent Vaccinators.

Clinic Appointments

Clinic Appointments:
Increase in clinic and physician bookings with relative to increase in vaccinations due to pre-employment screening.

An increase in the number of staff not attending clinic appointments, with increase from 38 in April to 48 in May 2018. Follow up phone calls to identify key reasons for missing appointments.

Increase in the complexity of cases being referred to Occupational Health Clinicians and taking longer period of time to close out.

Appendices

1. Aggression & Violence Poster.
2. Executive Health & Safety Committee Minutes 10.4.18
3. Welcome Day Agenda
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost time incidents</td>
<td>Any injury claim resulting in lost time.</td>
</tr>
<tr>
<td>Lost time injury Frequency Rate</td>
<td>No of lost time Injuries per million hours worked. LTIFR (Lost Time Injury Frequency Rate) = (Number of Lost Time Injuries / Hours Worked) x 1,000,000.</td>
</tr>
<tr>
<td>Injury Severity Rate</td>
<td>Mathematical calculation that describes the number of lost hours experienced as compared to the number of hours worked. LTISR (Lost Time Injury Severity Rate) = (Number of Lost Hours / Hours Worked) x 1,000,000.</td>
</tr>
</tbody>
</table>
| Notifiable Injury/illness                 | (a) Amputation of body part, serious head injury, serious eye injury, serious burn, separation of skin from underlying tissue, a spinal injury, loss of bodily function, serious lacerations.  
(b) any admission to hospital for immediate treatment  
(c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance  
(d) any serious infection (including occupational zoonosis) to which carrying out of work is a significant factor, including any infection attributable to carrying out work with micro-organisms, that involves providing treatment or care to a person, that involves contact with human blood or bodily substances, involves contact with animals, that involves handling or contact with fish or marine mammals.  
(e) any other injury/illness declared by regulations to be notifiable. |
| Notifiable Incident                       | An unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person’s health or safety arising from an immediate or imminent exposure to an escape, spillage or leakage of a substance; an implosion explosion or fire; an escape of gas or steam; an escape of a pressurised substance; an electric shock; a fall or release from height of any plant or substance; collapse or partial collapse of a structure; interruption of the main system of ventilation in an underground excavation or tunnel; collision between two vessels or capsize; or any other incident declared by regulations to be a notifiable incident. |
| Notifiable Event                          | Death of a person, notifiable injury or illness or a notifiable incident.                                                                                                                                   |
| Pre-Employment                            | Health screening for new employees.                                                                                                                                                                          |
| Worker                                    | An individual who carries out work in any capacity for the PCBU e.g. employee, contractor or sub-contractor, employee of the sub-contractor, employee of labour hire company, outworker, apprentice or trainee, person gaining work experience, volunteer. |
| Reasonably Practicable                    | Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters.e.g the likelihood of the hazard/risk occurring and the degree of harm resulting, what the person knows about hazard/risk and how to eliminate/ minimise the risk and the cost associated with elimination of the hazard/risk |
## Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Commission</td>
</tr>
<tr>
<td>ARF</td>
<td>Audit, Risk and Finance</td>
</tr>
<tr>
<td>BBFE</td>
<td>Blood and/or Body Fluid Exposure</td>
</tr>
<tr>
<td>CCS</td>
<td>Central Clinical Services</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>EAP</td>
<td>Employee Assistance Programme (Counselling)</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
<tr>
<td>EMIC</td>
<td>Emergency Medicine &amp; Integrated Care</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HSNO</td>
<td>Hazardous Substance New Organisms Act</td>
</tr>
<tr>
<td>HSWA</td>
<td>Health and Safety at Work Act 2015</td>
</tr>
<tr>
<td>IRS</td>
<td>Incident Reporting System</td>
</tr>
<tr>
<td>JCC</td>
<td>Joint Consultative Committee</td>
</tr>
<tr>
<td>LTI</td>
<td>Lost Time Injury</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MMC</td>
<td>Middlemore Central</td>
</tr>
<tr>
<td>OHSS</td>
<td>Occupational Health and Safety Service</td>
</tr>
<tr>
<td>PHCS</td>
<td>Primary Health &amp; Community Services</td>
</tr>
<tr>
<td>PEHS</td>
<td>Pre-Employment Health Screening</td>
</tr>
<tr>
<td>SAP</td>
<td>Surgical, Anaesthesia &amp; Perioperative</td>
</tr>
<tr>
<td>SPEC</td>
<td>Safe Practice and Effective Communication</td>
</tr>
<tr>
<td>WellNZ</td>
<td>Injury Management Third Party Administrator</td>
</tr>
</tbody>
</table>
Background
As the number of presentations to the Emergency Department (ED) have increased (10,000 per month) so too have the number of incidents involving aggression. This is not limited to just patients, but also visitors. Understanding the reasons behind the increase is multi-factorial including increased violence in the community, changes to police processes and management of patients with mental health (MH).
• There has been increased reports of violence (both verbal and physical) towards frontline ED staff in the last 12 months.
• In 2017, 85 recorded incidents of physical assault to ED employees, versus 30 in 2016.
• Security calls to ED are trending upwards; in Dec 2017 there were 65 calls, versus 31 calls in Dec 2016.
• Staff report 30% confidence in dealing with aggressive / abusive patients.
• Additionally we believe the incidence of abuse is actually higher than our figures show. Many instances of verbal abuse go unreported due to the complexities of reporting formally, and care of all emergency patients taking precedence over paper-work.

Aim
Our aim is to provide visible and clear interventions, to improve staff confidence to safely manage the aggression by having the ability to access help quickly when feeling threatened.

Method
We began with a survey within the ED, encouraging all members of the multi-disciplinary team (MDT) to participate. Staff were asked how confident they felt when faced with verbal threats. This was followed by audits that were conducted in 5 areas of ED, Waiting Room / Triage, Adult Assessment, Medical Assessment, Adult Short Stay, and Kids First ED. The purpose of the audits was to quantify the incidents and identify the type of abuse experienced by staff. This involved easy access to staff feedback boxes where staff could promptly report incidents of aggressive / abusive abuse.

After identifying the extent of the challenges, the ED MDT in collaboration with MH and police, worked towards developing tools and resources to assist staff confidence in managing aggressive behaviour.

Interventions Implemented
Situational Aggression Tool (SAT) and Graded Approach to the Behaviourally Disturbed Patient (GABDP) Guideline, were introduced and familiarised to staff to improve staff action when faced with patient aggression. The SAT assesses risk of aggression towards staff with visual prompts of de-escalation. While the GABDP is a management flowchart used by nurses to manage patients on different levels of risk once assessed as non-competent.

A dedicated Behaviour Team was established to be the primary point of contact after failed initial de-escalating attempts. This team has the ability and experience to make decisions on the next step. Team members include Security, the Senior Medical Officer and the Acute Clinical Nurse Manager.

Medications for managing behaviourally disturbed patients were made up in an allocated box and placed in secure but accessible locations within the ED. Should the patient be assessed as non-competent according to clinicians’ judgement, the SMO would embark on the GABDP providing a plan that the MDT could anticipate. A callout emergency number was established that contacted all members of the team simultaneously.

Re-design of the ED Assessment Form, allows the experienced ED Triage nurse to identify potential risk, and ensure police details are available for the MDT. The front page visibility also reminds staff of how to escalate.

We are in the process of implementing de-escalation education designed by a local Mental Health Nurse for staff which is also part of a National roll-out, to assist with our aim.

Personal alarms were distributed to nurses on the floor for use if their safety was at risk. Further audits were conducted across the department measuring staff confidence in managing patients, and staff understanding of previous guidelines.

Results
Audit data collected over three weeks (17th April to 8th May 2018), in ED demonstrated high incidences of verbal abuse experienced by ED frontline staff (65 cases = approx. 3 per day).

Based on this data, we can see there is likely significant under-reporting; 85 recorded incidence in 2017 vs a potential 1126 non-recorded incidents in 2018. Reporting an incident formally takes approx. 17 minutes. Based on the 3 weeks of data, if all 65 incidents in that time were reported it would take 17 hours - this is time the staff don’t have.

Most commonly reports of abuse involved verbal aggression towards female staff – insults, swearing, personal threats, but there were also multiple accounts of physical aggression, (not included in audit).

Prior to implementation of our 7 interventions, staff audits revealed overall staff confidence was at only 30% for managing aggressive patients / support people, and clarity / knowledge of previous guidelines were rated at only 29%. This rose to 50% for both questions in the early stages of intervention and education. Once final roll out has been completed, we expect confidence to further increase as staff engage with the tools as standard practice.

Conclusion
The main purpose of all these interventions is to acknowledge the concern expressed by the ED staff. Initial survey following implementation of the outlined supports have shown improvement in nurses’ confidence dealing with aggressive or abusive patients and support people. Staff confidence will continue to be monitored throughout the rest of the education and implementation process surrounding these tools. Feedback shows appreciation of the change in process and a culture shift has been noted in the department. Staff reportedly feel more able to express concern for their safety and act on this appropriately / with appropriate resources. Reports of abuse by frontline staff continue to be reported and it is evident staff tolerance of aggression or abuse is reducing as a result of this research.

Elyse Oh (Registered Nurse, Emergency Department)
Acknowledgment also to Louise Fianel, Aashleigh Howan, Laura Bonney, Sharon Cox, Debby Hailstone and Jeremy Stockton.
Executive Health, Safety and Wellbeing Committee  
10 April, 9.00am – 10.30am  
KA Meeting Room 107

<table>
<thead>
<tr>
<th>#</th>
<th>Agenda Item</th>
<th>Action</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review of previous meetings minutes and actions</td>
<td></td>
<td>Elizabeth</td>
</tr>
</tbody>
</table>
| 2  | Management - Health and Safety report | **Discussion:** Southern DHB notice for heat in rooms over summer. We have a list of problematic/ hot rooms in the hospital/ campus. Humidity is also a problem. We need to have a look at the legal implications of working in high temperatures. There was no budget to install heat pumps in previous years and have identified Esme Green as a risk.  
**Action:** Keep monitoring this risk. Map clinical areas for possible heat pump installations and make decisions based on identified hazardous areas. Timeline is 3 months. | Elizabeth/ Philip |

**Discussion:** ACC considering significant change to the Experience Rating schema – measure against records and outcomes of our conduct not the industry average. Explained the Injury Claims Management process to the committee.

**Discussion:** Current state of the DHB. Phillip, Marie and Elizabeth had a meeting about this on 9 April 2018. An internal audit must be done, as well as continued internal air and asbestos monitoring.

**Action:** Draft a paper to employ and external auditor. Assign FTE and have the auditor assist the internal and peer auditors. Project plan and time frames for processing and monitoring of the building risks (water & asbestos).

**Discussion:** Water safety monitoring – Testing and flushing of
pipes and knowing the risks. The risk monitoring needs to sit under
the H&S Team.

**Action:** Contact microbiologists for policies on water care
monitoring. Report back on issues with the infrastructure and main
water line testing.

**Discussion:** Focus on Safety at work, bullying and occupational
health. MOH wants us to focus on Occ Health.

Do we have the issues identified and what can we do about it?
The main ones are: Moving & Handling and Bullying & Harassment.
Focus on the positive of bullying & harassment, for e.g. rewarding
kindness.

Doctorate leadership that is emotionally intelligent, as it will pull
through to the entire organisation.

Completely Fabulous App – Asks staff daily on their state of
happiness to identify times of unhappiness.

The RMO’s have a funded app like this. This is not a wise time to
revisit the staff experience survey.

**Discussion:** Regional Audit Report to AFR. Near misses being
recorded cannot be reported on. We need a clinical risk system
that is more user friendly. We need to keep pushing the reporting
of incidents.

Is there a way that we can reconfigure what systems we currently
make use of?

No, we will need to reconfigure our systems.

There is a placeholder at R&P if we wish to join in on this.

Waitemata are in the process of getting a new H&S system.

We need a framework around the audits and what is required.

**Discussion:** Staff Vaccinations. We need to get a process and policy
in place that informs new staff members to get vaccinated before
they start working at CMDHB, with the focus on high risk areas.
The Board will have to be on board with this policy.

The manager needs to phone the staff that declined the boostrix
vaccination.

NZNO made it clear that we cannot contact staff that decline
vaccinations, as it makes the staff uncomfortable. Can we ask a
question in the midwifery interview, whether they are open to
vaccinations?

The problem is that Midwifery has a low uptake for all vaccines.

Whooping cough/ pertussis is very important in Maternity & would
like to know which midwives aren’t being vaccinated for this.

**Action:** Locate previous Q&A/ Policy for vaccinations in high risk areas.

| 3. Safe Handling/ Safety Culture |  |  |
|----------------------------------|-----------------------------------------------|
| **Discussion:** Safe Moving and Handling and Safety Culture. The staff perspective needs to change with regards to safety – possible ‘No Blame’ culture if they use the safety tool. Can we roll out the safety toolkit with the manual handling? Yes we can do that – possibly make a video on safety. Safety and Patient Safety Culture is different, so we must differentiate between these two and focus on Safety Culture. Can learn a lot from the AirNZ Safety Video. Look at layers/mechanisms we need to address in our video. We need to make out own video that relates to our people and include our own staff in this process. Knows the Safety Manager at AirNZ that can possibly provide information about their safety culture.  |
| **Action:** Add to the work plan. Identify areas to improve in patient care and safety. | Elizabeth | Phillip |
|  | | Marie |
|  |  | Jenny |
|  |  | Elizabeth/Marie |
|  |  | Philip |

| 5. Facilitates update | Unable to report anything relating to Facilities. We have 3 different risk reporting lines at Counties, hence a minor risk can become a major risk. The Board brought in Gavin Johnson and Brent Sutton to conduct an audit – Asbestos was pointed out as a key risk. | Philip |

| 6. Other business | Attending a Mental Health App presentation at WellNZ, that could possibly beneficial to our staff. | Marie |

# Welcome Day Part 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:45am</td>
<td>Registration and Meet at Ko Awatea café @ Middlemore Hospital</td>
</tr>
<tr>
<td>8:00am</td>
<td>Welcome Powhiri or Whakatau</td>
</tr>
<tr>
<td>9:00am</td>
<td>Housekeeping CM Health</td>
</tr>
<tr>
<td></td>
<td>- Overview – Demographics</td>
</tr>
<tr>
<td></td>
<td>- Cultural Diversity</td>
</tr>
<tr>
<td></td>
<td>- Every day in CM Health</td>
</tr>
<tr>
<td></td>
<td>- Services and the Community</td>
</tr>
<tr>
<td></td>
<td>- Employees</td>
</tr>
<tr>
<td></td>
<td>- Information Workbook</td>
</tr>
<tr>
<td>9:40am</td>
<td>Asian Health Overview</td>
</tr>
<tr>
<td>9:50am</td>
<td>Pacific Health Overview</td>
</tr>
<tr>
<td>10:00am</td>
<td>CEO Welcome</td>
</tr>
<tr>
<td>10:15am</td>
<td>Maori Health Overview</td>
</tr>
<tr>
<td>10:30am</td>
<td><strong>Morning Tea</strong> (catered)</td>
</tr>
<tr>
<td>10:50am</td>
<td>Legal</td>
</tr>
<tr>
<td></td>
<td>- Health &amp; Disability Consumer Code of Rights</td>
</tr>
<tr>
<td></td>
<td>- Privacy Act 1993</td>
</tr>
<tr>
<td>11:15am</td>
<td>Values Refresh</td>
</tr>
<tr>
<td>11:45am</td>
<td>Finding your way around Southnet</td>
</tr>
<tr>
<td></td>
<td>- Workperks</td>
</tr>
<tr>
<td></td>
<td>- Environment Sustainability</td>
</tr>
<tr>
<td>12:00pm</td>
<td>Fire</td>
</tr>
<tr>
<td>12:15pm</td>
<td>Security</td>
</tr>
<tr>
<td>12:30</td>
<td>Health and Safety</td>
</tr>
<tr>
<td>1:00pm</td>
<td>NZNO and PSA</td>
</tr>
<tr>
<td><strong>1:30pm</strong></td>
<td>Lunch Break</td>
</tr>
<tr>
<td><strong>2:00pm</strong></td>
<td>Close of Welcome Day Part 1 and Start of Welcome Day Part 2</td>
</tr>
<tr>
<td>Time</td>
<td>Topic</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>07:55 - 12:30</td>
<td>Welcome Day including Powhiri</td>
</tr>
<tr>
<td>12:30 - 13:00</td>
<td>Occupational Health &amp; Safety</td>
</tr>
<tr>
<td>13.00 – 13.30</td>
<td>PSA and NZNO</td>
</tr>
<tr>
<td>13:30 – 14:00</td>
<td>Lunch Break</td>
</tr>
<tr>
<td>14:00 – 14:30</td>
<td>Ko Awatea LEARN* - demonstration session</td>
</tr>
<tr>
<td>14:30 – 15:00</td>
<td>Login Distribution by Programme Coordinator</td>
</tr>
<tr>
<td>15:00 – 16:00</td>
<td><strong>eLearning modules</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Patient Safety Training 2018: Allied/HCA's with Patient Contact</td>
</tr>
<tr>
<td></td>
<td>▪ i.PM Smart Search and Amend for CM Health</td>
</tr>
<tr>
<td></td>
<td><strong>Lunch Break</strong></td>
</tr>
<tr>
<td>08:25 – 10:15</td>
<td>IS Training – Clinical Portal</td>
</tr>
<tr>
<td>10:15 – 12:00</td>
<td><strong>eLearning module (continue)</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Fire Safety for Counties Manukau Health staff (2018)</td>
</tr>
<tr>
<td></td>
<td>▪ Engaging Effectively With Maaori - eLearning package</td>
</tr>
<tr>
<td>12:00 - 12:30</td>
<td>Lunch Break</td>
</tr>
<tr>
<td>12:30 - 13:30</td>
<td>Smoke-free Training</td>
</tr>
<tr>
<td>13:30 - 15:00</td>
<td>Creating the Counties Experience</td>
</tr>
<tr>
<td>15:00 – 16.00</td>
<td>Introduction to Allied Health Professional Development</td>
</tr>
</tbody>
</table>

**Thank you & Welcome to Counties Manukau Health**
Notes for New Employees:

- Any issues with the logins, please contact IS services on ext. 52266.
- All new staff is expected to report to their hiring manager after Welcome Day.
- Middlemore Staff Cafeteria “Everest Café” - The Everest Café is located on the ground floor of the Edmund Hillary Building.
  - Opening Hours are 6:30am to 7:30pm
  - Food Served from 7am - 7pm
# AGENDA

Welcome Day – Nursing (Part 1 and 2)

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Room Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAY 1 – PART 1 (18/6/18)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07:55 - 12:30</td>
<td>Welcome Day including Powhiri</td>
<td>Ko Awatea Lecture Theatre 1</td>
</tr>
<tr>
<td>12:30 - 13:00</td>
<td>Occupational Health &amp; Safety</td>
<td>Ko Awatea Lecture Theatre 1</td>
</tr>
<tr>
<td>13:00 – 13:30</td>
<td>PSA and NZNO</td>
<td>Ko Awatea Lecture Theatre 1</td>
</tr>
<tr>
<td>13:30 – 14:00</td>
<td><strong>Lunch Break</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DAY 1 - Nursing Only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00 – 14:30</td>
<td>Ko Awatea LEARN* - demonstration session</td>
<td>Ko Awatea Computer Lab 2</td>
</tr>
<tr>
<td>14.30 – 15.00</td>
<td>Login Distribution by Programme Coordinator</td>
<td>Ko Awatea Lecture Theatre 1</td>
</tr>
<tr>
<td>15:00 – 16:00</td>
<td>Time to sort Security ID, Access Card, Car parking and eLearning modules</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>DAY 2 - PART 2 (19/6/18)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08:25 – 10:15</td>
<td>IS Training: Clinical Portal</td>
<td>Ko Awatea Computer Lab 2</td>
</tr>
<tr>
<td>10:15 – 12:00</td>
<td>Continue with eLearning module</td>
<td>Ko Awatea Computer Lab 2</td>
</tr>
<tr>
<td><strong>12:00 - 12:30</strong></td>
<td><strong>Lunch Break</strong></td>
<td></td>
</tr>
<tr>
<td>12:30 - 13:30</td>
<td>Smoke-free Training</td>
<td>Ko Awatea Room 216</td>
</tr>
<tr>
<td>13:30 - 15:00</td>
<td>Creating the Counties Experience</td>
<td>Ko Awatea Room 213</td>
</tr>
<tr>
<td>15:00 – 16:00</td>
<td>Nursing Professional Development</td>
<td>Ko Awatea Room 213</td>
</tr>
</tbody>
</table>

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Counties Manukau District Health Board
Corporate Affairs and Communications Report

Recommendation

It is recommended that the Board:

**Receive** the Corporate Affairs and Communications Report for the period 1 May to 31 May 2018.

**Prepared and submitted** by Donna Baker, General Manager Communications and Engagement and Margie Apa, Director Population Health & Strategy.

Purpose

This paper provides an update on Corporate Affairs and Communications activity for the period 1 May to 31 May 2018.

Major Issues or Events

**Condition of hospital buildings**
A large amount of information about the CM Health buildings has now been released to multiple media outlets through the OIA process. Media coverage has reduced although there have been follow-up queries mostly relating to the process involved in recladding the Scott building, the seismic status of the Galbraith building and future use.

**Galbraith’s seismic rating**
The communications team proactively released a statement about the seismic rating of the Galbraith building and the options facing the board. The information about the building is now clearly displayed on site at Middlemore Hospital by way of light boxes and information brochures at the entries to the Galbraith building.

**Palms Lifecare (Heritage Lifecare)**
An earlier article about the poor care delivered to an elderly resident at Palms Lifecare in Pukekohe was revisited when the resident’s daughter complained about the report written by CM Health concerning the provider. A subsequent meeting was held between CM Health and the complainant in which CM Health was able to reassure the complainant of the seriousness with which it has approached this incident. This was reflected in the resulting article.

**APAC Forum**
Information released to NZ Herald through the OIA process resulted in a story that focused on the cancellation costs of APAC and asked questions about the cost benefit of the event.

**Media and Email Enquiries**

For this period the generic communications inbox received 242 emails, 92 were not related to communications issues and, where appropriate, were referred to other departments and services at the CM Health. We logged and responded to 78 media phone requests. During the same period we received 24 OIA requests and released 45 responses. These included the 14 media OIAs around CM Health facilities, which included 400 documents released through our website. Follow-up queries are being handled through the media process.

**Routine Sector Communications**
**Connect+ magazine**
The June/July edition of Connect+ will be published week commencing 25 June. This issue showcases our wonderful Nursing and Midwifery staff at the annual Nursing and Midwifery awards. It also highlights the great achievements of our staff across CM Health, as well as some exciting programmes in our community. We introduce our new Board Chair Vui Mark Gosche, share an update on what’s happening in the Galbraith building, and focus on the flu with a positive immunisation story, and ways in which staff can still get their vaccine.

**Internal communication campaigns and activities**

**Flu Campaign**
We have continued to see an increase in numbers of staff being vaccinated (64% as at 28 May), however some staff remain reluctant to be vaccinated. In order to increase numbers further, the following communication activities have been implemented:

A survey was sent via the Daily Dose to understand the reasons why some people choose to have the flu vaccine and some people do not. We also asked if there was one thing we could do to persuade people to get the vaccine.

- 175 people responded (157 have had the vaccine. 18 people have not)
- The three top reasons why people haven’t had the vaccine:
  - It will make me sick
  - I’m fit and healthy, so don’t need it
  - I have no time
- 27 people had the flu vaccine at their GP practice, however, did not fill out a form and send it back to Occupational Health & Safety.

**Suggestions on how to make it easier for people to get the vaccine included:**
- More information on what the vaccine is for; e.g. what type of flu does the vaccine cover?
- Continue to offer incentives like a free coffee.
- House calls to the wards on night shift.
- If non-clinical department, the vaccine clinic could visit the location or non-clinical departments could book for the vaccine.
- Provide a private space for people who are scared of needles. Maybe have a bed available.
- Provide more information on how it will protect you, your family and the patients from getting sick.
- Advise staff this is a safety issue for both them and their patients.
- Have more information why you can still have the vaccine with medical reasons.
- Keep offering information about risk and benefit.
- Inform staff before the immunisation is available, not just as it is being offered.
Other activities
• The pop-up clinic was moved to a more staff user area - in Paataka Place.
• Email sent to people who haven’t had the vaccine and a request for them to discuss their reasons why with their manager.
• GMs continue to receive data as to how their teams are performing.
• A separate survey is being undertaken with the midwives, followed by an information session by Dr David Holland.
• We will continue to showcase our star vaccinators and areas in Paanui and the Daily Dose.

Transition from 888 to 777
• On 28 May, the emergency response number 888 changed to 777. This transition was supported with a range of communication material.

Turn Around Plan
• Work continues with the relevant GMs on developing communication plans for approved initiatives that have a medium to high stakeholder and media risk. This included the successful closure of the patient shuttle service at Manukau SuperClinic which was reported in the manukau Courier.
• A general update about TAP was posted on Paanui and included in the Daily Dose. To date, over 1700 staff have accessed the TAP web page.

Strike communication plan
• A communications plan is being developed for a potential nursing and midwifery strike in July 2018. This plan will include internal and external requirements, with a focus on media management.
• If a strike notice is issued, regular national teleconferences will be set up with DHB communication leads to ensure consistent approach and key messages.

Pink shirt day
• Communication support provided for Pink Shirt Day, which is about working together to stop bullying by celebrating diversity and promoting positive social relationships. Staff were encouraged to wear pink and decorate their areas. Posters, screensaver and web banner created. Information shared on internal and external channels.
Nursing and Midwifery Awards
• Coverage of the Nursing and Midwifery Awards in our internal and external channels. Our Facebook post reached over 3000 people with 78 likes and 23 comments.

External communication key activities
• The external comms team met with Dr Ashraf Choudhary in May to discuss priority health areas for the Asian community in the CM Health region and how we might effectively communicate with this population group. Areas of particular concern were bowel cancer and diabetes. Dr Choudhary offered to share CM Health messages with his extensive networks in the community.

• Comms is working with the Child, Youth and Maternity team to promote the release of the online video, Look at You –Aroha Atu, Aroha Mai. The video is on the CM Health website and shows how babies are social and communicate right from birth. The video supports parents, whaanau and those working with babies to understand their social and emotional needs in the first three months of life and is available in English, Maaori, Samoan, Tongan, Niuean and Cook Island Maori.

• Comms supported the Alcohol Harm Minimisation team workshop and facilitated a stakeholder identification and analysis session for this work. The team is consulting with the Health Promotion Authority (HPA) on a new video series ‘Don’t know, don’t drink’ on the topic of alcohol consumption during pregnancy.

• Comms has worked with Maaori Workforce Development and Whaanau Ora teams to produce resources for Mataariki. Events include a SUDI display at Middlemore Hospital, social media wahakura competition and a quiz.

• Comms provide support to the Fanau Ola team to celebrate Samoan Language Week (SLW) (27 May – 2 June) producing a social media video, sharing photos of the SLW activities at the Treetop crèche, a quiz and promotion of the celebration event at Ko Awatea.

• Comms is working with the recruitment team to create compelling content to market CM Health vacancies to people living outside of New Zealand. Current CM Health staff that came to New Zealand to work have been surveyed and the information gathered will inform the recruitment and marketing materials for this audience.
• The GP communications tool Medinz continues to roll out. The comms team attended a content workshop in June. The comms team has agreed to post HealthPathways messaging while HealthPathways apply to Healthpoint to publish directly themselves.

• Youth Week – comms produced a Facebook video with Otahuhu College student Saline Pagaialii on her volunteer work in the South Auckland community.

• World Smokefree Day – comms produced a video with Merenaite and Olivia from our Smokefree team to encourage whaanau to stop smoking, as well as promote the Smokefree services.

• Safe Sleep Programme – we’re working with the Safe Sleep team on updating their PEPE flyer, as well as promote PEPE messages throughout Mataariki. This includes running a wahakura competition on the Healthy Together Facebook page and running a survey with Maternity staff to capture information on their knowledge of safe sleep. Tina Higgins (Youth Health Service Development Manager) went onto Radio 531pi’s health segment in early June to talk about SUDI and the importance of safe sleep.

• Our Monthly Maternity (OMM) e-update was published in early May and early June.

• Women’s Health and Newborn 2017/2018 annual report – we’re collecting content for the report and will be compiling all the content ready for editing and proofing before final content sign-off.

• Programme W&AT! (Pacific workforce) – We’re currently working on collateral for students and their whaanau on the programme. An A5 DLE information card has been created and is now sitting with the Pacific team for final sign-off. We’re also working with the team on champion stories that we can utilise on the Healthy Together Facebook page, as well as for the Programme’s website.

• Bowel Screening Programme – the National Bowel Screening Programme is being rolled out in the Counties Manukau area from the end of June (when the invitation letters are being sent to residents). Bowel screening will be offered to everyone aged 60 to 74 who are eligible for publicly funded healthcare and a resident in the Counties Manukau area.

A comprehensive overview of the Communications for this programme has been previously circulate, including examples of collateral and links to videos

• Research Week 2018 (18-21 June) - Research Week is an annual CM Health event which celebrates the research taking place across the DHB. Comms has produced collateral and is supporting the promotion of the event internally.

• Integrated Care – Comms is supporting Hospital in the Home, Health Coaching, Planned Proactive Care and Enhancing Primary Care. We have produced fact sheets, case studies, change packages and other collateral to support the projects. We are also updating their information on CM Health’s website.

• Comms is working with Ko Awatea on the plan to transition Ko Awatea’s website to CM Health’s website and also on aligning Ko Awatea’s brand to CM Health’s brand.

• Equity in Health campaign – we continue to provide support for the campaign, and are currently working on collateral for the planned pregnancy and healthy weight gain in pregnancy teams.

• Healthy Together Technology – we supported the transition of Concerto to Clinical Portal, producing collateral and raising awareness internally.
Digital Channels

**Website** ([www.countiesmanukau.health.nz](http://www.countiesmanukau.health.nz))

Our site shows a decrease in traffic this period, in particular on nights and weekends. This may lend credit to our ‘Right care for you’ messaging, resulting in our population seeking care in more appropriate options.

![Figure 1 Web Site Data Metrics from Google Analytics](image)

**Social Media**

This was a consistent period of growth for all social channels in May. As with last period, we are aiming for more engagement with our messaging, and an increase in engagement per post was achieved on all channels with LinkedIn being the exception. We are noticing an increase in engagement on Twitter now that this channel’s messaging is aligned much more closely with our Facebook pages. Posts that celebrate our staff and video content continue to be popular with our audience.

<table>
<thead>
<tr>
<th></th>
<th>Total Followers</th>
<th>Follower Increase</th>
<th>Messages Sent</th>
<th>Impressions</th>
<th>Impressions per Post</th>
<th>Engagements (incl. post clicks)</th>
<th>Engagements per Post</th>
<th>Post Clicks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health Facebook</td>
<td>7,703</td>
<td>2.00%</td>
<td>27</td>
<td>65,225</td>
<td>2,419</td>
<td>12,707</td>
<td>470.6</td>
<td>9,949</td>
</tr>
<tr>
<td>Healthy Together Facebook</td>
<td>8,662</td>
<td>0.10%</td>
<td>11</td>
<td>25,110</td>
<td>2,282</td>
<td>3,340</td>
<td>303.6</td>
<td>2,307</td>
</tr>
<tr>
<td>CM Health Twitter</td>
<td>2,573</td>
<td>0.82%</td>
<td>15</td>
<td>7,615</td>
<td>507</td>
<td>97</td>
<td>6.5</td>
<td>37</td>
</tr>
<tr>
<td>CM Health Linkedin</td>
<td>5,428</td>
<td>1.46%</td>
<td>6</td>
<td>9,867</td>
<td>1,644</td>
<td>386</td>
<td>64</td>
<td>310</td>
</tr>
</tbody>
</table>

![Figure 6 Summary of Reach and Engagement Metrics for each social media channel](image)
Audience Growth Metrics

<table>
<thead>
<tr>
<th></th>
<th>Totals</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fans</td>
<td>24,336</td>
<td>+1.0%</td>
</tr>
<tr>
<td>New Facebook Fans</td>
<td>160</td>
<td>+1.0%</td>
</tr>
<tr>
<td>New Twitter Followers</td>
<td>21</td>
<td>+0.8%</td>
</tr>
<tr>
<td>New LinkedIn Followers</td>
<td>78</td>
<td>+1.5%</td>
</tr>
<tr>
<td>Total Fans Gained</td>
<td>244</td>
<td>+1.0%</td>
</tr>
</tbody>
</table>

*Figure 7 Audience Growth Overview by social media channel CM Health Facebook*

**CM Health Facebook**

Our strategy on this channel of posting messages that celebrate staff and demonstrate our values within the DHB continues to be very popular. Our engagement per post continues to climb, with our top four posts all achieving over 1000 reactions per post and engagement rates of over 34%.

**Top four Posts by Reactions:**

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A massive thank you to our wonderful cleaners, orderlies and security team members for your service and commitment to CM Health and our community. This week we got the opportunity to celebrate long service awards of 10, 20+ years of service. We could not thank you enough for all the little things you do to make life easier and smoother for our patients and staff. #feelgoodfriday #StaffAppreciation #Kapai#Excellent #TeamCounties</td>
<td>2,701</td>
<td>58</td>
<td>35.6%</td>
<td>7,582</td>
</tr>
<tr>
<td></td>
<td>Manukau Surgery Centre 1st Floor may be leading the Privacy Competition with their creative messages about how we can best protect and respect the privacy of our patients. The challenge is on! Submit your entries to the Communications Team before Friday 11 May 2018. #PrivacyMatters#2018PAW</td>
<td>1,574</td>
<td>21</td>
<td>40.8%</td>
<td>3,860</td>
</tr>
<tr>
<td></td>
<td>Great to see staff supporting #PinkShirtDayNZ. Join the movement - Stand up. Speak up and Stop bullying.</td>
<td>1,436</td>
<td>2</td>
<td>36.5%</td>
<td>3,934</td>
</tr>
<tr>
<td></td>
<td>Thanks to everyone who attended the recent Nursing and Midwifery Awards, we had a great night celebrating our amazing staff. Congratulations to all our nominees and winners (some of which are shown below) for their outstanding achievements. We wouldn’t be able to do what we do without you!#teamwork #excellent #staffappreciation #NMA2018— with Roxy Buchanan.</td>
<td>1,064</td>
<td>18</td>
<td>34.2%</td>
<td>3,113</td>
</tr>
</tbody>
</table>

*Figure 8 Top 4 CM Health Facebook Posts by reactions*
**Healthy Together Facebook**

Video content is king on this channel. Our video that followed third year midwifery student, Maia, who wishes to join the graduate programme at CM Health was our most successful post across all channels achieving a massive 41.2% engagement rate.

Top four Posts by Reactions:

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.jpg" alt="Image" /></td>
<td>Following high school, and after a gap year that turned into two years, Rotorua born and raised Maia Jocie Wharekura began midwifery studies in 2015. She found her first year a bit of a struggle because she had left her support network of whaanau and friends back home when she went to Auckland to study. Maia soon made friends because “all the midwives are lovely”, and they became her support network during term time. Whaanau still played a big part in her success however, with lots of interest in her grades and assessments – “they want to be part of the journey with me, they’re very proud”...</td>
<td>1,528</td>
<td>101</td>
<td>41.2%</td>
<td>3,708</td>
</tr>
<tr>
<td><img src="image2.jpg" alt="Image" /></td>
<td>Happy Samoan Language Week to you and your whaanau from Amon, Delilah, Elizabeth, Eti, Foloi, Jack, Junior, Lu-Ellen, Ola and Peisi who work in the Pacific Health team, recruitment, human resources, workforce development, physiotherapy and mail and reprographic services at Middlemore Hospital. The theme this year is ‘Alofa atu nei. Alofa mai taeao – Kindness given. Kindness gained’. For a list of events and activities in your area visit the Ministry for Pacific Peoples website: <a href="https://bit.ly/2xewBfx">https://bit.ly/2xewBfx</a></td>
<td>1,071</td>
<td>29</td>
<td>14.8%</td>
<td>7,235</td>
</tr>
<tr>
<td><img src="image3.jpg" alt="Image" /></td>
<td>Coming down with a cold? Your family doctor is there to help or call Healthline on 0800 611 116 for advice. If your doctor is closed, your local A&amp;M clinic is available. For more information, visit our website: <a href="https://bit.ly/2kfpBFV">https://bit.ly/2kfpBFV</a></td>
<td>195</td>
<td>-</td>
<td>2.98%</td>
<td>6,541</td>
</tr>
<tr>
<td><img src="image4.jpg" alt="Image" /></td>
<td>When third-year midwifery student and mother of four, Natasha Paul gets a call from the hospital that a woman is in labour, her two youngest children say “Are you going to catch the baby?”; and when she returns home, they want to know “Was it a boy or a girl?”. South-Auckland born and raised, Natasha says the support of her husband and tamariki has...</td>
<td>163</td>
<td>1</td>
<td>6.08%</td>
<td>2,681</td>
</tr>
</tbody>
</table>

*Figure 9 Top 4 Healthy Together Posts by reactions*
**CM Health Twitter**

Following our newly implemented strategy of messaging that aligns closely with our Facebook messaging we saw an impressive 591% increase in engagement this period. We plan to continue this new strategy and hope to see consistent engagement numbers.

Top four Posts by impressions:

<table>
<thead>
<tr>
<th>Tweets</th>
<th>Top Tweets</th>
<th>Tweets and replies</th>
<th>Promoted</th>
<th>Impressions</th>
<th>Engagements</th>
<th>Engagement rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health @cmdhbd May 22</td>
<td><img src="image" alt="Promote" /></td>
<td></td>
<td></td>
<td>1,164</td>
<td>12</td>
<td>1.0%</td>
</tr>
<tr>
<td>CM Health @cmdhbd May 11</td>
<td><img src="image" alt="Promote" /></td>
<td></td>
<td></td>
<td>870</td>
<td>5</td>
<td>0.7%</td>
</tr>
<tr>
<td>CM Health @cmdhbd May 16</td>
<td><img src="image" alt="Promote" /></td>
<td></td>
<td></td>
<td>665</td>
<td>9</td>
<td>1.4%</td>
</tr>
<tr>
<td>CM Health @cmdhbd May 10</td>
<td><img src="image" alt="Promote" /></td>
<td></td>
<td></td>
<td>664</td>
<td>11</td>
<td>1.7%</td>
</tr>
</tbody>
</table>
CM Health LinkedIn

With a new messaging approach that is a combination of recruitment and Facebook-style content, we’re seeing high engagement rates on this channel; however we feel there’s still room to grow. Our LinkedIn has the fastest growing audience amongst all our channels but slightly lower engagement. Our audience is only 54% local, so messages that highlight our positive Counties culture could be a good way to engage some of our international audience.

Top Posts by Engagement:

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Join the team" /></td>
<td>Do you have a passion for improving the health and care of patients and their families? Are you an exceptional improvement expert looking for a high profile, strategic leadership role? Do you thrive in an innovative and diverse environment? We’ve got just the opportunity you’ve been looking for! You can find out more about this great role, and apply here: <a href="https://bit.ly/2ruZNIM">https://bit.ly/2ruZNIM</a></td>
<td>148</td>
<td>0</td>
<td>6.47%</td>
<td>2,024</td>
</tr>
<tr>
<td><img src="image2.png" alt="JobFest" /></td>
<td>Counties Manukau Health along with the Metro DHB’s are excited to be attending JobFest on May 24th! Come to The ASB Showgrounds and meet us on the day to learn more about what an entry level roles and health career opportunities looks like! #JobFest2018 #CMHJobs #YouthPledge</td>
<td>94</td>
<td>0</td>
<td>4.19%</td>
<td>1,670</td>
</tr>
</tbody>
</table>

Figure 11 LinkedIn Top Posts by engagement

Appendix

1. Programme W&AT! Information.
Programme W&AT! aims to increase the total number of Pacific people employed in the New Zealand health sector. It will help prepare Pacific students to transition from secondary school to relevant tertiary study and into employment by offering a seamless support network.

**Tertiary Essentials (workstream one)** provides additional support during the transition phase from secondary to tertiary study. Students will be able to access these services from Year 13 through to the end of semester one of the first year of tertiary study.

Services include the hosting and coordinating of regional sessions focused on:

- completing the application processes for StudyLink, student loans and tertiary institutes
- seeking out information and application processes for relevant scholarships
- developing skills for APA referencing, critical thinking and academic writing
- engaging with aiga and community

**Tertiary support (workstream two)** provides complementary support services to tertiary students. Scope and role clarity is very important in this workstream as the students’ academic learning is primarily the responsibility of the tertiary institute they attend. The project will work closely with each tertiary’s Pacific Liaison Officer and/or team to ensure that students take full advantage of the services and programmes available to them on campus.

The programme design has identified that key responsibilities will be to:

- handshake students back to tertiary partners in the first instance e.g. for changing papers, academic tutoring etc
- support existing tertiary programmes and services and liaise with tertiary partners to offer combined support services
- provide additional support and assist with access to alternative services (e.g. community organisations) if student is handshaken back to the programme for further assistance
- liaise with delivery partners Brown Touch Down (a regional tertiary student led Community Organising group) if additional peer to peer academic mentoring is required
• provide workplace pastoral care (i.e. while on placement), support cultural connections in the workplace, assist with linking theory to clinical and meeting professional competencies
• support students to link back from workplace to their tertiary Pacific Liaison Officer and/or team

**Employment Essentials (workstream three)** focuses on providing support during the transition phase from tertiary to employment with a key focus on assisting students to be more competitive when going through recruitment processes. A 1:1 professional mentoring programme focused on supporting the transition to the workplace forms part of this workstream.

Students will be able to access these services in the last year of tertiary study. Services include the facilitating and coordinating of sessions on:

• support with CV and cover letter writing (addressing competencies as outlined in the position description)
• first impressions, corporate standards and organisation values
• interview preparation, interview techniques, live demonstrations and role play opportunities
• assessment centre models specific to each DHB recruitment process
• building self-confidence and self-awareness
• emotional and cultural intelligence
• providing insight into each DHB’s recruitment processes and requirements

Similar to workstream two, in this workstream we will continue to build on:

• providing workplace pastoral care (i.e. while on placement), support cultural connections in the workplace, assist with linking theory to clinical and meeting professional competencies
• support students to link back from workplace to their tertiary Pacific Liaison Officer and/or team

**Professional mentoring programme**

Additionally, students who register for the 1:1 professional mentoring programme will be matched with a suitable health or business professional for mentoring and support. The mentoring programme focuses on the development of ‘soft skills’ and prepares the students for the workforce covering topics such as:

• relationship management and networking with peers/managers/clients/stakeholders
• leadership in the workplace
• emotional and cultural intelligence
• building capability and skills in order to influence
Recommendation

It is recommended that the Board:

Receive the Finance and Corporate Business Report.

Note that this paper presents an overview of the latest available financial position as presented to the Audit Risk and Finance Committee at their meeting of 6 June 2018.

Submitted by: Margaret White, Chief Financial Officer

Glossary

ACC  Accident Compensation Corporation  JPA  Joint Partnership Agreement
AMH  Adult Mental Health  KA  Ko Awatea
AMHU  Adult Mental Health Unit  LSP  Licencing Solution Partners
ARDS  Auckland Regional Dental Service  MBIE  Ministry of Business Innovation & Employment
ARF  Audit Risk & Finance Committee  MH  Mental Health
ARTR  Authority to Recruit  MoH  Ministry of Health
BNZ  Bank of New Zealand  NOS  National Oracle Solution
CFO  Chief Financial Officer  NRA  Northern Region Alliance
CIC  Capital Investment Committee  NRLTIP  Northern Region Long Term Investment Plan
CM  Counties Manukau  NZ  New Zealand
CPI  Consumer Price Index  NZHPL  New Zealand Health Partnerships
DBC  Detailed Business Case  PAYE  Pay As You Earn
DIA  Department of Internal Affairs  PBFF  Population Based Funding Formula
DFA  Delegated Financial Authority  PHO  Primary Health Organisation
DHB  District Health Board  POAG  Procurement Organisation Advisory Group
ELT  Executive Leadership Team  PO  Purchase Order
FPESC  Finance, Procurement Supply Chain  RFP  Request for Proposal
FSA  Food Service Agreement  TAP  Turn Around Plan
FTE  Full Time Equivalent  UoO  University of Otago
GST  Goods and Services Tax  WIES  Weighted Inlier Equivalent Separations
HT2020  Healthy Together  WIP  Work in Progress
IDF  Inter District Flows

Purpose

The purpose of this paper is to provide the Board with an overview of the latest available financial position as presented to the Audit Risk and Finance Committee at their meeting of 6 June 2018.
Financial Report for the period ended 30 April 2018

YTD 30 April 2018 the consolidated result was $0.084m favourable to budget. Performance by operating arm is presented in Table 1.

Table 1: Statement of Performance by Operating Arm for the period ended 30 April 2018

<table>
<thead>
<tr>
<th>Net Result</th>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April 2018</td>
<td>April 2018</td>
<td>Act Bud Var</td>
</tr>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>Hospital Provider</td>
<td>4,077</td>
<td>3319</td>
<td>758</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>(3,782)</td>
<td>(3,726)</td>
<td>(56)</td>
</tr>
<tr>
<td>Ko Awatea</td>
<td>(1,215)</td>
<td>(1,241)</td>
<td>26</td>
</tr>
<tr>
<td>Provider</td>
<td>(920)</td>
<td>(1,648)</td>
<td>728</td>
</tr>
<tr>
<td>Funder</td>
<td>(48)</td>
<td>412</td>
<td>(460)</td>
</tr>
<tr>
<td>Governance</td>
<td>(270)</td>
<td>(47)</td>
<td>(223)</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(1,238)</td>
<td>(1,283)</td>
<td>45</td>
</tr>
</tbody>
</table>

Provider

Hospital Provider position is $0.621m adverse to budget YTD. YTD acute demand has contributed to higher clinical costs and has displaced elective volumes necessitating a $5.5m provision for under delivery of the MoH Elective discharge target. These costs have been offset by the one off contribution from the ACC arrears programme which YTD is $7.1m favourable to budget. The full year forecast reflects our commitment to increase clinical capacity in quarter three and four to respond to immediate demand pressures and prepare for 2018 winter.

Integrated care is $0.763m favourable to budget YTD, reflecting management of contracts and FTE.

Ko Awatea is $1.576m favourable to budget YTD reflecting structural changes together with crystallisation of $608k provisions in the month of February 2018.

Funder

The Funder Arm is $1.085m adverse to budget YTD, primarily attributable to a continued provisioning for anticipated IDF wash-up exposure YTD $6.511m (hospital and community services), mitigated by $2.018m below budget PHO enrolments and $3.136m Mental Health surplus over and above budget due to delayed implementation of various initiatives and delay in commissioning of the Acute Mental Health Unit.

Governance

The Governance Arm is $0.549m adverse to budget YTD, reflecting $0.651m contracted resource covering vacancies and one off projects, write down of previously capitalised (WIP) costs part offset by $0.287 vacancies held for HT2020 as programmes wind down. Full year forecast reflects the $3.0m cladding settlement.
Volume Summary

Sustained acute demand, compounded by anaesthetist and theatre space shortages continue to impact Elective surgery volumes. YTD 30 April 2018 Elective WIES were 8.4% adverse to contract and discharges are 4.5% less than the same period last year. Outsourced surgical volumes account for 7% of the YTD elective volumes. A recovery plan is in place to make up a measure of lost volumes for the balance of the year via the delivery of additional lists, increased clinics and outsourcing. The Director of Hospital Services is working with the MoH Elective Unit to confirm our ability to recognise a level of non-case weight discharges e.g. Avastin. As indicated above the YTD result includes a $5.5m provision for revenue claw back.

Forecast Year End Position and Underlying Operating Variance as at 30 April 2018

The full year forecast remains in line with budget at $20m deficit. As at 30 April 2018, performance against the organisation wide savings programme was $8.613m unfavourable. This together with increased clinical costs have been offset by a number of net favourable one off transactions, predominantly reflecting a combination of ACC Arrears and close out of Balance Sheet provisions. When added to the underspend in Mental Health, these mask the operating result (deficit), as outlined below (refer Table 2). YTD April 2018 the underlying operating deficit is $26.891m being $12.897m variance to budget.

Table 2: Analysis of Underlying Operating Result

<table>
<thead>
<tr>
<th>Apr-18</th>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Var</td>
<td>Act</td>
</tr>
<tr>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>Reported Operating Surplus (Deficit)</td>
<td>(1,238)</td>
<td>(1,283)</td>
<td>45</td>
</tr>
<tr>
<td>MH Underspend</td>
<td>(1,049)</td>
<td>0</td>
<td>(1,049)</td>
</tr>
<tr>
<td>Net Favourable One Offs</td>
<td>(3,094)</td>
<td>0</td>
<td>(3,094)</td>
</tr>
<tr>
<td>Underlying Operating Deficit net of AMH and One Off</td>
<td>(5,381)</td>
<td>(1,283)</td>
<td>(4,098)</td>
</tr>
</tbody>
</table>

Note: The level of Mental Health Underspend has been adjusted to reflect MoH confirmation of 2017/18 ring-fence (April 2018).

The full Financial Variance Report for the period ended 30 April 2018 is presented in Appendix 1 of this report.
Appendix 1 – Financial Major Variance Report for the period ended 30 April 2018

YTD 30 April 2018 the consolidated result is $0.084m favourable to budget.

Table 3: Statement of Revenue and Expenditure for the period ended 30 April 2018

<table>
<thead>
<tr>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
<th>Act $000</th>
<th>Bud $000</th>
<th>Var $000</th>
<th>Act $000</th>
<th>Bud $000</th>
<th>Var $000</th>
<th>Bud $000</th>
<th>Forecast $000</th>
<th>Var $000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>135,873</td>
<td>132,570</td>
<td>3,303</td>
<td>1,349,548</td>
<td>1,328,944</td>
<td>20,604</td>
<td>1,594,070</td>
<td>1,618,276</td>
<td>24,206</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>3,965</td>
<td>3,097</td>
<td>868</td>
<td>32,886</td>
<td>31,078</td>
<td>1,808</td>
<td>37,478</td>
<td>42,141</td>
<td>4,663</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>139,838</td>
<td>135,667</td>
<td>4,171</td>
<td>1,382,434</td>
<td>1,360,022</td>
<td>22,412</td>
<td>1,631,548</td>
<td>1,660,417</td>
<td>28,869</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Expenses       |              |           |          |          |          |          |          |          |          |               |          |
| Personnel      | 52,305       | 51,507    | (898)    | 511,313  | 515,611  | 4,298    | 621,256  | 615,842  | 5,414    |               |          |
| Outsourced Personnel | 1,608    | 941      | (667)    | 17,924   | 9,460    | (8,464)  | 11,339   | 19,961   | (8,622)  |               |          |
| Outsourced Services | 6,951    | 5,585    | (1,366)  | 57,384   | 57,119   | (265)    | 68,368   | 69,335   | (967)    |               |          |
| Funder Provider Payments | 58,937   | 57,515   | (1,422)  | 591,798  | 575,161  | (16,637) | 690,191  | 707,904  | (17,713) |               |          |
| Clinical Sup.  | 9,451        | 9,572     | 121      | 99,388   | 97,522   | (1,866)  | 117,474  | 120,191  | (2,717)  |               |          |
| Infrastructure | 5,424        | 6,148     | 724      | 59,127   | 62,324   | 3,197    | 74,751   | 75,795   | (1,044)  |               |          |
| **Operating Exp** | 134,676   | 131,268   | (3,408)  | 1,336,934| 1,317,197| (19,737) | 1,583,379| 1,609,028| (25,649) |               |          |
| Operating surplus | 5,162     | 4,399     | 763      | 45,500   | 42,825   | 2,675    | 48,169   | 51,389   | 3,220    |               |          |
| Depn.          | 3,663        | 2,661     | (1,002)  | 27,454   | 26,610   | (844)    | 31,932   | 32,962   | (1,030)  |               |          |
| Interest       | -            | 27        | 27       | 7        | 268      | 261      | 322      | 144      | 178      |               |          |
| Capital Chg.   | 2,737        | 2,994     | 257      | 31,948   | 29,940   | (2,008)  | 35,928   | 38,325   | (2,397)  |               |          |
| **Net Surplus/(Deficit)** | (1,238) | (1,283) | 45       | (13,909) | (13,993) | 84       | (20,013) | (20,042) | (29)     |               |          |

Commentary on Major Variances

**Crown Revenue**

YTD was $20.604m favourable to budget, reflecting the following:

- favourable unbudgeted MoH funding for Disability Support Services Pay Equity (offset in Funder Provider Payments) $8.962m;
- favourable accrual for System Level Measures funding paid to PHO’s during the month (offset in Funder Provider Payments) $0.829m;
- favourable unbudgeted revenue for After Hours Service provided on behalf of other DHB’s and PHO’s (offset in Funder Payments) $1.740m;
- favourable Social Investment Board Funding from Sate Services Commission $1.547m (offset by expenditure);
- favourable IDF wash up adjustment on inflows $2.046m;
- ACC arrears initiative $7.1m;
- capital charge funding $3.221m (offset by Capital Charge Cost);
- Provision for $5.5m revenue claw back associated with under delivery of elective programme.
Other Revenue

YTD was $1.808m favourable to budget attributable to:
- favourable private patients $1.3m, predominantly Tahitian Burns and co-payments;
- favourable non-residents revenue $1.225m;
- additional revenue from bad debts recovered $0.394m;
- favourable research grants $0.624m;
- unfavourable $1.1m Pharmacy revenue (offset in infrastructure);
- Reduction in donation revenue $0.947m with the likelihood of further reductions in future months.

Personnel and Outsourced Personnel

YTD net personnel costs are $4.166m unfavourable, part offset by $0.265m favourable outsourced services. This result reflects under delivery of savings programme initiatives targeted at organisational redesign together with cost pressure from clinical demand – total FTEs are 6,364 (budget 6,344).

Funder Provider Payments

YTD was $16.637m unfavourable to budget, reflecting the following:
- unfavourable $8.962m accrual for Disability Support Services Pay Equity (offset in Crown Revenue);
- unfavourable $0.829m payments for System Level Measures paid to PHO’s during the month (offset in Crown Revenue);
- unfavourable $2.536m payments for After Hour costs (offset in Crown Revenue);
- unfavourable $8.557m accrual for the current estimate of IDF shortfall for the 17/18 year;
- favourable $2.932 Mental Health spend lower than budget due to delay in commissioning of AMHU and NGO procurement;
- favourable $2.108m PHO enrolments below budget.

Clinical Supplies

YTD was $1.866m unfavourable to budget, reflecting high clinical demand and significant increase in treatment disposables, instruments, equipment and pharmaceuticals together with delayed procurement savings.

Depreciation, Interest and Capital Charge

Depreciation and Capital Charge YTD is $2.591m unfavourable reflecting timing of capitalisation of projects, and a revision in the capital charge (offset by capital charge funding).
### Statement of Financial Position as at 30 April 2018

<table>
<thead>
<tr>
<th></th>
<th>Act $000</th>
<th>Bud $000</th>
<th>Var $000</th>
<th>June 2017 $000</th>
<th>Movement $000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petty Cash</td>
<td>8</td>
<td>8</td>
<td>-</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Bank</td>
<td>59,197</td>
<td>37,399</td>
<td>21,798</td>
<td>20,894</td>
<td>38,303</td>
</tr>
<tr>
<td>Trust</td>
<td>831</td>
<td>893</td>
<td>(62)</td>
<td>883</td>
<td>(52)</td>
</tr>
<tr>
<td>Prepayments</td>
<td>1,734</td>
<td>2,307</td>
<td>(573)</td>
<td>2,307</td>
<td>(573)</td>
</tr>
<tr>
<td>Debtors</td>
<td>57,279</td>
<td>51,043</td>
<td>6,236</td>
<td>46,990</td>
<td>10,289</td>
</tr>
<tr>
<td>Inventory</td>
<td>7,214</td>
<td>7,484</td>
<td>(270)</td>
<td>7,484</td>
<td>(270)</td>
</tr>
<tr>
<td>Assets Held for Sale</td>
<td>5,320</td>
<td>5,320</td>
<td>-</td>
<td>33,743</td>
<td>(28,423)</td>
</tr>
<tr>
<td><strong>Total current Assets</strong></td>
<td>131,583</td>
<td>104,454</td>
<td>27,129</td>
<td>112,309</td>
<td>19,274</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>212,420</td>
<td>212,420</td>
<td>-</td>
<td>212,420</td>
<td>-</td>
</tr>
<tr>
<td>Buildings, Plant &amp; Equip</td>
<td>619,156</td>
<td>635,290</td>
<td>(16,134)</td>
<td>600,455</td>
<td>18,701</td>
</tr>
<tr>
<td>Investment Property</td>
<td>1,626</td>
<td>1,627</td>
<td>(1)</td>
<td>1,627</td>
<td>(1)</td>
</tr>
<tr>
<td>Information Technology</td>
<td>4,092</td>
<td>15,054</td>
<td>(10,962)</td>
<td>4,259</td>
<td>(167)</td>
</tr>
<tr>
<td>Information Software</td>
<td>561</td>
<td>561</td>
<td>-</td>
<td>561</td>
<td>-</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>4,416</td>
<td>4,516</td>
<td>(100)</td>
<td>4,416</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>842,271</td>
<td>869,468</td>
<td>(27,197)</td>
<td>823,738</td>
<td>18,533</td>
</tr>
<tr>
<td>Accum. Depreciation</td>
<td>(175,943)</td>
<td>(178,316)</td>
<td>2,373</td>
<td>(151,706)</td>
<td>(24,237)</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td>666,328</td>
<td>691,152</td>
<td>(24,824)</td>
<td>672,032</td>
<td>(5,704)</td>
</tr>
<tr>
<td>Work In-progress</td>
<td>74,765</td>
<td>68,291</td>
<td>6,474</td>
<td>50,551</td>
<td>24,214</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>741,093</td>
<td>759,443</td>
<td>(18,350)</td>
<td>722,583</td>
<td>18,510</td>
</tr>
<tr>
<td>Investments in Assoc</td>
<td>45,549</td>
<td>49,167</td>
<td>(3,618)</td>
<td>41,834</td>
<td>3,715</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>918,225</td>
<td>918,225</td>
<td>5,161</td>
<td>876,726</td>
<td>41,499</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>112,468</td>
<td>105,535</td>
<td>3,933</td>
<td>92,119</td>
<td>20,349</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>12,008</td>
<td>12,164</td>
<td>(156)</td>
<td>6,164</td>
<td>5,844</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>16,093</td>
<td>14,689</td>
<td>1,404</td>
<td>13,324</td>
<td>2,769</td>
</tr>
<tr>
<td>Loans</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>36,589</td>
<td>27,968</td>
<td>8,621</td>
<td>26,370</td>
<td>10,219</td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>90,629</td>
<td>90,629</td>
<td>150</td>
<td>86,587</td>
<td>4,042</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>267,787</td>
<td>253,835</td>
<td>13,952</td>
<td>224,060</td>
<td>43,727</td>
</tr>
<tr>
<td><strong>Working Capital</strong></td>
<td>(136,204)</td>
<td>(149,381)</td>
<td>13,177</td>
<td>(111,751)</td>
<td>(24,453)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>650,438</td>
<td>659,229</td>
<td>(8,791)</td>
<td>652,666</td>
<td>(2,228)</td>
</tr>
<tr>
<td><strong>Non-Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Term Loans</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Employee Provisions (non-current)</td>
<td>18,717</td>
<td>18,717</td>
<td>-</td>
<td>22,658</td>
<td>(3,941)</td>
</tr>
<tr>
<td>Trust and Special Funds</td>
<td>832</td>
<td>898</td>
<td>(66)</td>
<td>898</td>
<td>(66)</td>
</tr>
<tr>
<td>Insurance Liability - non current</td>
<td>931</td>
<td>931</td>
<td>-</td>
<td>931</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>20,480</td>
<td>20,546</td>
<td>(66)</td>
<td>24,487</td>
<td>(4,007)</td>
</tr>
<tr>
<td><strong>Crown Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Equity</td>
<td>407,635</td>
<td>424,288</td>
<td>(16,653)</td>
<td>399,789</td>
<td>7,846</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>291,395</td>
<td>283,552</td>
<td>7,843</td>
<td>283,553</td>
<td>7,842</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(69,072)</td>
<td>(69,157)</td>
<td>85</td>
<td>(55,163)</td>
<td>(13,909)</td>
</tr>
<tr>
<td><strong>Total Crown Equity</strong></td>
<td>629,958</td>
<td>638,683</td>
<td>(8,725)</td>
<td>628,179</td>
<td>1,779</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>650,438</td>
<td>659,229</td>
<td>(8,791)</td>
<td>652,666</td>
<td>(2,228)</td>
</tr>
</tbody>
</table>
Commentary on Major Variances

- Bank was $21.798m favourable to budget. Net cash flows from operations (revenue, expenses and payroll) was $9.4m favourable to budget. Fixed Assets were $24.697m favourable to budget representing the delayed timing of capital spend for major capital projects. These have been mainly offset by the timing of the budgeted $24.5m funding from the Ministry of Health for the AMHU now expected to be received in tranches, of which $7.8m was received in April 2018.

- Debtors were $6.236m higher than budget attributable to accrued debtors, predominantly Pharmac rebate, and a movement in debtor’s provision of $1.9m.

- Total Fixed Assets were $24.824m lower than budget reflecting timing major capital projects spend.

- Creditors were $3.933m favourable to budget reflecting Capital spend $5.239m lower than planned and an adjustment to Capital Charge of $0.983m.

- GST and PAYE were $1.404m lower than budget attributable to timing.

- Payroll Accrual and Clearing were $8.621m higher than budget reflecting timing of Salaries and Wages payments.

- Favourable working Capital $13.177m is mostly attributable to delayed capital expenditure YTD $24.824m, $6.236m higher debtors (including a reduction of the bad debt provision), $3m settlement for cladding, offset by timing variance $16.6m funding from the Ministry of Health for AMHU.
**Statement of Cash flow for the period ended 30 April 2018**

<table>
<thead>
<tr>
<th></th>
<th>Month</th>
<th></th>
<th></th>
<th>YTD</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
<td>Var</td>
<td>Act</td>
<td>Bud</td>
<td>Var</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td></td>
</tr>
<tr>
<td><strong>Cash flows from Operating activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Revenue</td>
<td>133,299</td>
<td>133,225</td>
<td>74</td>
<td>1,341,552</td>
<td>1,330,885</td>
<td>10,667</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4,404</td>
<td>2,880</td>
<td>1,524</td>
<td>34,591</td>
<td>28,914</td>
<td>5,677</td>
<td></td>
</tr>
<tr>
<td>Interest rec.</td>
<td>179</td>
<td>217</td>
<td>(38)</td>
<td>1,846</td>
<td>2,170</td>
<td>(324)</td>
<td></td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suppliers</td>
<td>(77,908)</td>
<td>(73,678)</td>
<td>(4,230)</td>
<td>(814,912)</td>
<td>(797,202)</td>
<td>(17,710)</td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td>(48,140)</td>
<td>(51,115)</td>
<td>2,975</td>
<td>(500,476)</td>
<td>(512,348)</td>
<td>11,872</td>
<td></td>
</tr>
<tr>
<td>Capital charge</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(18,664)</td>
<td>(17,964)</td>
<td>(700)</td>
<td></td>
</tr>
<tr>
<td><strong>Net cash from Operations</strong></td>
<td>11,834</td>
<td>11,529</td>
<td>305</td>
<td>43,937</td>
<td>34,455</td>
<td>9,482</td>
<td></td>
</tr>
<tr>
<td><strong>Cash flows from Investing activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed assets</td>
<td>(5,239)</td>
<td>(10,276)</td>
<td>5,037</td>
<td>(38,852)</td>
<td>(63,549)</td>
<td>24,697</td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>(36)</td>
<td>(174)</td>
<td>138</td>
<td>(2,997)</td>
<td>(7,333)</td>
<td>4,336</td>
<td></td>
</tr>
<tr>
<td>Restricted &amp; Trust Funds</td>
<td>(55)</td>
<td>-</td>
<td>(55)</td>
<td>(54)</td>
<td>-</td>
<td>(54)</td>
<td></td>
</tr>
<tr>
<td><strong>Net cash from Investing</strong></td>
<td>(5,330)</td>
<td>(10,450)</td>
<td>5,120</td>
<td>(41,903)</td>
<td>(70,882)</td>
<td>28,979</td>
<td></td>
</tr>
<tr>
<td><strong>Cash flows from Financing activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sale of Asset</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>28,423</td>
<td>28,423</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other Non-Current Liability</td>
<td>7,846</td>
<td>1</td>
<td>7,845</td>
<td>7,846</td>
<td>24,509</td>
<td>(16,663)</td>
<td></td>
</tr>
<tr>
<td><strong>Net cash from Financing</strong></td>
<td>7,846</td>
<td>1</td>
<td>7,845</td>
<td>36,269</td>
<td>52,932</td>
<td>(16,663)</td>
<td></td>
</tr>
<tr>
<td><strong>Net increase / (decrease)</strong></td>
<td>14,350</td>
<td>1,080</td>
<td>13,270</td>
<td>38,303</td>
<td>16,505</td>
<td>21,798</td>
<td></td>
</tr>
<tr>
<td>Opening cash</td>
<td>44,855</td>
<td>36,327</td>
<td>8,528</td>
<td>20,902</td>
<td>20,902</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Closing cash</strong></td>
<td>59,205</td>
<td>37,407</td>
<td>21,798</td>
<td>59,205</td>
<td>37,407</td>
<td>21,798</td>
<td></td>
</tr>
</tbody>
</table>

**Reconciliation Summary**

|                        |       |          |        |       |          |        |        |
| Net Surplus/(Deficit)  | (1,238) | (1,283) | 45     | (13,909) | (13,993) | 84     |
| Add/(Less) non-cash items |       |          |        |       |          |        |        |
| Impairment of Intangibles |       |          |        |       |          |        |        |
| Depn                  | 3,663  | 2,661    | 1,002  | 27,454 | 26,610   | 844    |
| Add/(Less) Movements in Financial Position Items |       |          |        |       |          |        |        |
| Debtor and Other Receivables | (1,787) | 55 | (1,842) | (9,716) | (4,053) | (5,663) |
| Inventories           | 73     | 73       | 270    |       | 270      |        |
| Creditors             | 6,965  | 9,703    | (2,738) | 29,014 | 23,838   | 5,176  |
| Employee Entitlements | 4,158  | 393      | 3,765  | 10,824 | 2,053    | 8,771  |
|                        | 9,409  | 10,151   | (742)  | 30,392 | 21,838   | 8,554  |
| **Net Cash flow from Operations** | 11,834 | 11,529 | 305    | 43,937 | 34,455   | 9,482  |

**Commentary on Major Variances**

- YTD cash-flow from Crown Revenue is $10.667m favourable to budget, representing:
  - favourable $7.1m from the ACC arrears initiative;
  - favourable $8.9m Ministry of Health funding for Disability Support Services (offset in payments to suppliers);
  - Offset by the increase in debitors of $6.2m (timing).
• YTD payments to suppliers were $17.71m higher than budget, reflecting:
  ▪ October payment of $11.8m for 2016/17 IDF wash-up (not budgeted);
  ▪ unfavourable outsourced personnel, unfavourable clinical supplies together with the increased Funder Provider Payments.

• Employee Payments were $11.872m favourable to budget representing timing of the payment of payroll accruals.

• Fixed Assets $24.697m favourable to budget representing the timing of capital spend for major capital projects.

• Investments were $4.336m favourable to budget representing the NZHPL spend for NOS, not incurred in accordance with budget.

• Restricted and Trust Funds decreased by $0.055m as historic patient funds were remitted Treasury.

• Other Non-Current Liability $16.663m adverse to budget is attributable to the capital injection from the Ministry of Health for the AMHU now expected to be received in tranches rather than the budgeted payment in advance. First tranche of $7.846m was received in April 2018 as forecast, balance now expected in the 2018/19 2019/20 financial years.

**Treasury Report – 30 April 2018**

<table>
<thead>
<tr>
<th></th>
<th>$NZ 000's</th>
<th>Interest Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base operating cash *</td>
<td>$59,157</td>
<td>2.48%</td>
</tr>
<tr>
<td>Overdraft</td>
<td>$0</td>
<td>2.98%</td>
</tr>
</tbody>
</table>

*$41m tagged for capital projects

The interest rate is the rate on the last day of the month as advised by NZHPL, who manage the sector cash sweep for cash funds on hand and the BNZ rate applying to drawn debt. As at 30 April 2018, the BNZ facility limit was $75m for CM Health. This facility is reviewed annually based on the final year end results reported to the MoH.
Recommendation

It is recommended that the Board:

Receive the proposed 2018/19 capital plan.

Note that the 2018/19 capital plan was recommended to proceed to Board at the 6 June Audit Risk and Finance Committee meeting.

Note that the DHB capital requirement for 2018/19 is $69m funded as follows:
- $27.2m from 2018/19 depreciation free cash flow budget;
- $11.3m of the clinical equipment capital requirements have been identified as candidates for leasing finance, of which $1.5m cash will be required to fund the leases in 2018/19;
- $9.975m of the 2018/19 capital spend will be funded from the net land sale proceeds of $28.4m;
- $3m from Scott settlement proceeds; and
- $17.4m of capital spend will be funded from equity injections received in 2018/19 for the AMHU and Scott Re-clad projects.

Note that these capital requirements exclude any business cases still scheduled to go to the Capital Investment Committee whereby additional equity injection funding will be sought.

Note that the current capital plan excludes $3.4m of planned Facilities Master Planning and Business Case development costs that will be capitalised to major strategic projects. Discussions are underway with the MoH regarding regional seed funding for these projects.

Note this plan is predicated on our ability to achieve a $10m deficit position for the 2018/19 budget. In the event that the final agreed deficit position is greater than $10m, there would need to be further prioritisation of the capital requirements for 2018/19, or we would need to obtain confirmation regarding deficit support from the MoH to fund the cash shortfall.

Note any additional capital requirements not in the 2018/19 Board approved capital plan will need to be funded by either reprioritisation, donation revenue or equity funding from the Ministry of Health. Invest to save cases will be considered on a case by case basis.

Approve the proposed 2018/19 Capital Plan subject to confirmation of MOH support for the 2018/19 operating and cash position.

Prepared and submitted by Timneen Taljard – Deputy Chief Financial Officer - Corporate, endorsed by Margaret White – Chief Financial Officer

Glossary
CMDHB Counties Manukau District Health Board
CM Health Counties Manukau Health
ARF Audit Risk and Finance Committee
AMHU Adult Mental Health Unit
NZHPL NZ Health Partnerships Limited
Purpose

The purpose of this paper is to provide ELT with an update regarding the proposed 2018/19 capital plan and seeks endorsement to proceed to ARF and Board for approval. The paper outlines:

a) Strategic context underlying the 2018/19 capital plan.

b) Capital requirements vs funding sources for 2018/19.

Strategic Context underlying the 2018/19 capital plan

The strategic intent for CMDHB Capital Investment is to ensure key enabling assets are in place to support sustainable delivery of health services. Investment decisions are made in the context of the overall DHB vision, goals and objectives and in alignment with the DHB strategic themes.

Due to limited funding, capital prioritisation has focused on identifying the most urgent and critical Capital required to keep the business running; address the highest and most significant risks and consider affordability for the DHB. Clinical equipment capital reflects replacement of existing capital items with no allowance for new clinical equipment. Proposals for new investment will be assessed on merits of each case, requiring an “invest to save” focus.

Cash flow timing for projects approved in prior years also means that there is less “free” cash available overall.

A financing strategy is being pursued in the form of leasing where appropriate. Only those assets that are considered suitable for leasing will be leased e.g. diagnostic equipment where the DHB needs to maintain technology. A case by case assessment of each lease will be performed in terms of value for money and compliance with the accounting standards. Comparative lease quotes will be obtained from a regionally approved panel of approved suppliers. The operational affordability of this strategy will be considered as part of the overall DHB Opex budgeting process. We are also developing proposals to be funded by the Crown, mainly for Immediate Demand and Facilities Remediation Programme. As part of the Long Term Investment Planning process, we will work with the northern region DHBs and healthAlliance to identify sustainable financing options for IT/IS Capital requirements, as well as our local needs over the long term.

Capital requirements vs funding sources for 2018/19 year

The funding available for Capital for 2018/19 and its sources is summarised in table 1 below. The DHB capital requirement for 2018/19 is $69m funded as follows:

- $27.2m from 2018/19 depreciation free cash flow budget;
- $11.3m of the clinical equipment capital requirements have been identified as candidates for leasing finance, of which $1.5m cash will be required to fund the leases in 2018/19;
- $9.975m of capital (supporting clinical capacity) spend will be funded from the net land sale proceeds of $28.4m (refer appendix 4);
- $3m from Scott settlement proceeds; and
- $17.4m of capital spend will be funded from equity injections received in 2018/19 for the AMHU and Scott Re-clad projects.

If the DHB were to achieve a $10m deficit position for the 2018/19 budget, there would be $28m to fund capital expenditure requirements for 2018/19. In the event that the final approved DHB deficit position is greater than $10m, there would need to be further prioritisation of the capital.
requirements for 2018/19 or we would need to obtain confirmation regarding deficit support from the MoH to fund the cash shortfall.

A list of prioritised clinical equipment items identified as priority, but unable to be funded, will be presented to the Middlemore Foundation for consideration for fundraising in 2018/19. Any revenue in this regard will be recognised as donation revenue.

The 2018/19 capital requirements noted in this paper exclude any business cases still scheduled to go to the Capital Investment Committee whereby additional equity injection funding will be sought i.e. Specialised Rehabilitation; Interim Manukau Theatres; Manukau Core Infrastructure.

The current capital plan excludes $3.4m of planned Facilities Master Planning and Business Case development costs that will be capitalised to major strategic projects. Discussions are underway with the MoH regarding regional seed funding for these projects.

Any additional capital requirements not in the 2018/19 Board approved capital plan will need to be funded by reprioritisation, donation revenue or equity funding from the Ministry of Health. “Invest to save” proposals will be considered on a case by case basis.

The CMDHB capital group will meet on a quarterly basis to review the progress against the approved capital plan and assess if any further prioritisation will be required.
Table 1: Capital requirements for 2018/19 year vs funding available

<table>
<thead>
<tr>
<th>Capital requirements</th>
<th>DHB funded</th>
<th>Leasing</th>
<th>Sale of land proceeds</th>
<th>Scott settlement proceeds</th>
<th>Equity injection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital projects approved in 2017/18 with a forecast 2018/18 capital spend (top sliced)</td>
<td>8,570</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMHU funded from equity injection</td>
<td>15,028</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scott reclad funded from equity injection and settlement proceeds</td>
<td>5,408</td>
<td></td>
<td></td>
<td>3,000</td>
<td>2,408</td>
</tr>
<tr>
<td>Clinical Equipment replacement bid (refer appendix 1)</td>
<td>14,819</td>
<td>8,159</td>
<td>6,660</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical equipment to be leased from 2017/18 approved budgets</td>
<td>4,672</td>
<td></td>
<td></td>
<td>4,672</td>
<td></td>
</tr>
<tr>
<td>Facilities bid (refer appendix 2)</td>
<td>5,203</td>
<td>5,203</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICT bid (refer appendix 3)</td>
<td>3,800</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate demand and remediation projects funded from land sale proceeds (refer appendix 4)</td>
<td>9,976</td>
<td></td>
<td></td>
<td>9,976</td>
<td></td>
</tr>
<tr>
<td>CFO Contingency (note 3)</td>
<td>1,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Capital requirements 2018/19</strong></td>
<td>68,976</td>
<td>27,232</td>
<td>11,332</td>
<td>9,976</td>
<td>3,000</td>
</tr>
</tbody>
</table>

Free cash flow requirement from 2018/19 opex budget  
Free cash flow available from 2018/19 opex budget  
Depreciation forecast in 2018/19 budget  
Less: Target Annual Plan Deficit ($10,000)  
Funding gap 777

Note 1: Cash for this capital spend is already in CMDHB bank account
Note 2: Capital spend matches the cash equity injection that will be received from the MOH
Note 3: $1,500k CFO contingency allows for any unplanned capital that may arise. This will only be used for urgent replacements to maintain current clinical or critical infrastructure demand, meet legislative requirements or urgent Health and Safety requirements and will be approved within the DFA Policy limits, subject to CFO approval.

As shown in the table above, there is a funding gap of $777k. This gap will be managed as a “run hot budget” whereby business cases and capital projects will be prioritised on a first come and assessed risk basis. Late submission for capital projects identified in the capital plan will run the risk that they will not be approved and have to be deferred to the 2019/20 capital plan for reprioritisation.

Appendices

1: Summary of the clinical equipment 2018/19 prioritised capital plan
2: Summary Facilities and engineering 2018/19 Prioritised Deferred Maintenance Capital Plan
3: Summary of the ICT 2018/19 Prioritised Capital Plan
4: Immediate demand and remediation projects funded from land sale proceeds
Appendix 1:
Clinical equipment 2018/19 Prioritised Capital Plan

For the development of the 2018/19 Asset and Capital replacement budget the Asset and Capital Committee have used the following prioritisation process:

- Useful life of equipment as determined by Clinical Engineering database and assessment and confirmation from the clinical services:
  - Obsolescence from suppliers
  - Condition of the asset – physical assessment
  - Age of the equipment
- Clinical need for the replacement (through meetings with Clinical Engineering and the Clinical Services):
  - Quantity of the devices available
  - Clinical impact of reduced capacity

The risk of limiting the 2018/19 replacement budget to $14.8m is that we have needed to further defer equipment considered ‘past its useful life but still functional with limited support’. The total deferred amounts to almost $13million. Some of these items will fail in 2018/19 and will need to be considered as contingency.

The risk of not having any budget for new equipment is potential inefficiencies in service delivery due where additional equipment would assist with flow and turnaround. These cases will be considered on an “invest to save” basis.
Appendix 2:
Facilities and engineering 2018/19 Prioritised Deferred Maintenance Capital Plan

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Sum of 18/19 Q1</th>
<th>Sum of 18/19 Q2</th>
<th>Sum of 18/19 Q3</th>
<th>Sum of 18/19 Q4</th>
<th>Sum of Prioritised 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building Gen.</td>
<td>70,510</td>
<td>130,590</td>
<td>206,250</td>
<td>356,850</td>
<td>764,200</td>
</tr>
<tr>
<td>Elec</td>
<td>20,000</td>
<td>135,530</td>
<td>139,930</td>
<td>764,200</td>
<td>295,460</td>
</tr>
<tr>
<td>Fire</td>
<td>40,800</td>
<td>139,700</td>
<td>143,000</td>
<td>265,000</td>
<td>588,500</td>
</tr>
<tr>
<td>HV</td>
<td>7,700</td>
<td>47,300</td>
<td>143,000</td>
<td>132,000</td>
<td>330,000</td>
</tr>
<tr>
<td>HVAC</td>
<td>57,789</td>
<td>127,123</td>
<td>267,468</td>
<td>472,180</td>
<td>924,560</td>
</tr>
<tr>
<td>Lifts</td>
<td>27,500</td>
<td>60,500</td>
<td>27,500</td>
<td>60,500</td>
<td>176,000</td>
</tr>
<tr>
<td>Medical specific</td>
<td>48,945</td>
<td>108,345</td>
<td>94,595</td>
<td>114,395</td>
<td>366,281</td>
</tr>
<tr>
<td>Others</td>
<td>50,000</td>
<td>65,750</td>
<td>148,500</td>
<td>230,750</td>
<td>495,000</td>
</tr>
<tr>
<td>Roading</td>
<td>25,000</td>
<td>35,693</td>
<td>82,368</td>
<td>131,499</td>
<td>274,560</td>
</tr>
<tr>
<td>Security</td>
<td>62,500</td>
<td>80,000</td>
<td>114,000</td>
<td>160,000</td>
<td>416,500</td>
</tr>
<tr>
<td>Water</td>
<td>40,040</td>
<td>74,360</td>
<td>171,600</td>
<td>286,000</td>
<td>572,000</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>430,784</td>
<td>889,361</td>
<td>1,533,811</td>
<td>2,349,104</td>
<td>5,203,060</td>
</tr>
</tbody>
</table>

The criteria used to derive a prioritised list of 2018/19 facilities and engineering capital replacement budget is as follows:

- Ensuring the equipment / service meet statutory requirements e.g. Passive fire protection works
- Based on ensuring equipment reliability and clinical performance. This is based on maintenance checks and monitoring asset performance of the previous year
- Age, obsolescence, normal wear and tear of assets / equipment
- Ensuring health and safety of staff
- Improvements requested for by services
- Future plans for the building or service

Facilities projects deferred were judged based on the above criteria. Repercussions associated with not doing certain works include increased risk of equipment failure and not meeting staff / CM Health expectations e.g., deferring air conditioning works in certain areas.
Appendix 3:
ICT 2018/19 Prioritised Capital Plan

Priority areas for capital funding in ICT for 2018/19 have been determined through a collaborative process with senior clinicians, managers and the Healthy Together Technology Steering Group. A call for Concept Papers was issued in December 2017. Papers were received from the majority of directorates and cover clinical and business applications that require upgrading or replacement due to:

- Being ‘sunset’ or end of life products in terms of support e.g. RL6 risk monitor system
- The improvements in patient safety or clinical efficiency that the upgrade/product provides e.g. Delphic AP upgrade
- A requirement to comply with national standards e.g. TrendCare

The concept papers were then presented to the HTT Steering Group and underwent prioritisation at a group level utilising the CM Health prioritisation matrices created by the Investment & Change Steering Group. This provided the basis for the Priority 1, 2 and 3 rankings. Further detailed discussions were then undertaken with senior clinicians and managers including Director of Patient Care, Clinical Director of IT and Director of Hospital Services to further refine the rankings. The P1 projects of work represent the systems where we are most likely to enhance the benefits already being realised from the HTT programme; improve clinical safety and provide more effective care to our patients.

The items that have been deferred to further years (i.e., P2 and P3) are due to the requirement to further understand the direction of the ISSP roadmap. For example; upgrades to systems such as OneStaff and Rapid Login/Citrix improvements are likely to be included in ISSP business cases within the next 12 to 18 months.

CM Health will also benefit from the Northern Region’s ICT Capital Plan that has been developed within the context of the Long Term Investment Plan (LTIP) and the Information Systems Strategic Plan (ISSP). The Regional CFO’s have directed healthAlliance to act prudently and to only plan what the region can fund, and remove reliance on centre funding. The Regional CFOs subsequently indicated a funding envelope for 2018/19 is $50.0m for ICT. CM Health’s portion of this funding is paid to healthAlliance in the CM Health opex budget via depreciation funding. With this limited amount of funding, trade-offs have been made to what investment we continue with (in flight), what level of clinical risk do we need to mitigate / and what risk can we live with, and how we can progress the clinical capability uplift in the ISSP.

<table>
<thead>
<tr>
<th>Priority 1 Investments</th>
<th>Priority</th>
<th>Category</th>
<th>Project type</th>
<th>FY18-19</th>
<th>FY19-20</th>
<th>FY20-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Workflow Suite (Orion Clinical Portal module)</td>
<td>1</td>
<td>Clinical effectiveness</td>
<td>Replacement</td>
<td>250</td>
<td>250</td>
<td>-</td>
</tr>
<tr>
<td>Enable IPM Bed Numbering (replace WIMs)</td>
<td>2</td>
<td>Clinical safety</td>
<td>Upgrade</td>
<td>400</td>
<td>250</td>
<td>-</td>
</tr>
<tr>
<td>Acuity Tool (Trendcare)</td>
<td>3</td>
<td>Clinical safety</td>
<td>Replacement</td>
<td>750</td>
<td>1000</td>
<td>-</td>
</tr>
<tr>
<td>Primary Care View</td>
<td>4</td>
<td>Clinical safety</td>
<td>New system</td>
<td>300</td>
<td>300</td>
<td>-</td>
</tr>
<tr>
<td>Prescribing Phase 2 (Hospital Wide Implementation)</td>
<td>5</td>
<td>Clinical safety</td>
<td>Upgrade</td>
<td>500</td>
<td>1,000</td>
<td>-</td>
</tr>
<tr>
<td>Community Health Systems Streamlining (Primary/Secondary Care)</td>
<td>6</td>
<td>Clinical effectiveness</td>
<td>Upgrade</td>
<td>300</td>
<td>250</td>
<td>-</td>
</tr>
<tr>
<td>Enhanced CDV Tree/Patient Timeline</td>
<td>7</td>
<td>Clinical effectiveness</td>
<td>Upgrade</td>
<td>100</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>CPATH - Point of Care ultrasound ED</td>
<td>8</td>
<td>Clinical effectiveness</td>
<td>New system</td>
<td>100</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Telehealth Implementation</td>
<td>9</td>
<td>Clinical effectiveness</td>
<td>Replacement</td>
<td>50</td>
<td>100</td>
<td>-</td>
</tr>
<tr>
<td>Implement Bed Management &amp; e-ward whiteboards</td>
<td>10</td>
<td>Clinical effectiveness</td>
<td>New system</td>
<td>550</td>
<td>400</td>
<td>400</td>
</tr>
<tr>
<td>eReferral IPM interface</td>
<td>11</td>
<td>Efficiencies</td>
<td>Upgrade</td>
<td>300</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>3800</td>
<td>3000</td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix 4:
Immediate demand and remediation projects funded from land sale proceeds

On 19 March 2018 the Minister of Health approved CMDHB applying the proceeds from the sale of the Manukau Super Clinic land for sub-$10 million remediation and capacity projects at Middlemore Campus. At time of writing the proceeds from the land sale has been tagged to the following projects:

<table>
<thead>
<tr>
<th>Capital Project Name</th>
<th>FMP Programme/Tranche</th>
<th>Indicative total project cost</th>
<th>Indicative use of land sale proceeds</th>
</tr>
</thead>
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Forecast spend

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<td>9,975,760</td>
<td>9,447,000</td>
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Prioritisation of these projects is tied to the assessments of the Galbraith building and associated Immediate Demand and Remediation plans.

Accordingly the phasing of these projects may change over time.
Counties Manukau District Health Board
Proposal to Establish a Major Capital Works Oversight Sub-Committee

Recommendations

It is recommended that the Board:

**Note** that this paper was endorsed by the Executive Leadership Team on 5 June to go forward to Board.

**Note** the significant capital investments proposed and complexity of works that are due to begin in the 2018 year that includes Scott Building Recladding and business cases in progress for major capital works.

**Agree** the establishment of a sub-committee of the Board named “Major Capital Works Oversight” sub-committee that will provide Governance assurance of the progress of major capital investments including their execution and the management of risk.

**Note** that this does not sidestep CEO delegated authorities or accountability but aims to ensure Board has its own independent expertise and that management have a way of assuring governance on an area of major risk to the organisation.

**Agree** the attached draft Terms of Reference which is an amended version of the original Facilities and Management and Planning sub-committee.

Prepared and submitted by: Margie Apa, Director, Population Health and Strategy; Chester Buller, Manager, Capital Works

Purpose

This paper seeks endorsement to establish a subcommittee of the Board to monitor and provide governance oversight of major capital works and its execution to construction.

Context

The major capital works that have been agreed and will proceed on the Middlemore Site is Scott Building recladding. This is a major works that may cost up to $27.5m and carries risks to impacting on the health and safety of patients and staff and disruption to services.

Other major works that are likely to proceed to design stage if they are agreed comprise:

- Specialised Rehab Centre
- Manukau Infrastructure
- Interim Manukau Theatres
- Manukau Radiology Phase 1
- Radiology Harley Gray
- Scott Dialysis and Cathlab
- Manukau Power Resilience.
This work represents $203 million of possible capital investment with construction works likely to proceed on two of CMH’s major sites of both acute and elective delivery.

Management Structure to Deliver

We have added additional resource to both the Master Planner function and the Facilities, Engineering and Asset Management (FEAM) Division to support the additional pressure on both their BAU and capital development function.

The FEAM Division is establishing a Project Director to provide oversight of major capital works including managing the sequencing of each discrete project. It is likely that this role will need to be supplemented with additional project management resource as business cases are signed off and able to proceed to design and build. These additional costs are likely to be capitalised.

Why Governance oversight is required?

The Institute of Directors advises that committees of a board can perform a valuable role in advancing the business of the Board as part of the internal governance controls of the organisation. Major capital works are in themselves complex challenge to internal control because they actual expenditure is many transactions, multiple sub-contractors with specialist expertise in different areas of construction and the project management of works requires intensive scrutiny to ensure compliance with construction regulations.

The last significant construction works – Harley Gray- was overseen by a subcommittee of the Board because it represented significant capital expenditure and risk because of its impact on the Middlemore site.

The current planned major capital works carry greater risks for the Board because:

- They are a mix of remediation and immediate demand cases;
- They are not in one building but are discrete projects on different parts of both the Middlemore and Manukau sites that will impact at different stages on services and patient/staff access and health and safety;
- They are taking place in a heated construction industry context where the major tier 1 and tier 2 companies are undergoing restructuring, workforce shortage and impact of global economy on cost of materials and managing risk inflating costs of building in New Zealand greater than inflation.

Committees of the Board can give more intensive scrutiny to specific aspects of the Board’s duties. A subcommittee does not replace Board decision making authority and should not interfere in the CEO’s responsibilities and accountability for organisation performance. The Board remains liable for actions of any committees and the CEO is still accountable.

Typical governance practice is to have standing committees (Institute of Directors) overseeing Investments, Risk, people and culture, health and safety, digital/technology. An effective subcommittee should help the aggregate the Board’s workload and provide transparency to the Board on how a particular area is being managed and provide assurance.

Major capital works of the scale we are proposing carries a wide range of issues that Boards need assurance is being managed:

- Oversight of procurement and probity to assure the Government the capital investment is being expended appropriately through internal control;
• Managing the potential inflationary effects of a heated construction market for both workforce (shortage), global markets (cost of materials) on the overall cost control of major works;
• Impact on service disruption and health and safety risks to patients and staff;
• Changes to the size and scale of CMH’s asset base and enabling infrastructure for future growth.

An option is to channel this oversight through the Audit Risk and Finance committee. This would add significantly to the responsibility of ARF where its focus may be best spent on providing oversight of the BAU financial performance of the organisation.

Similar to other Board subcommittees, the Board may seek additional membership that brings expertise and market intelligence that is not currently available within the Board. The current Board does not have members whom have significant experience of major construction works and/or experience in the construction and/or related industry. Co-opting expertise may also provide assurance to the Government and central agencies that there is expertise being applied to ensure works are managed effectively.

Attached is a Terms of Reference for comment and endorsement.

Appendix

1. Draft Terms of Reference
1 Establishment

1.1 The Committee is established by the Board of CMDHB under Schedule 3, Section 38 of the New Zealand Public Health and Disability Act 2000 (“The Act”).

2 Context
Throughout 18/19 CMDHB is seeking additional and will have received significant capital investment to remediate the current ageing infrastructure and add capacity to meet the service demand for population growth.

The sum of the investment – if approved – for the 18/9 – 20/21 year is more than [check with Marianne]. If realised, these investments will represent major changes in the Middlemore site and Manukau. These investments also represent major risks to health and safety, service disruption and internal control of expenditure.

The context for this investment and major works is a construction industry that is itself stretched for capacity (e.g. workforce) with costs of works increasing at rates higher than inflation.

3 Functions

2.1 The functions of the Major Capital Works Oversight are to:

a) provide advice to the Board on major CMDHB capital projects [threshold?] that have been signed off and deleted to the Sub-committee by the Board;

b) review the design and construction of CMDHB facilities;

c) monitor building projects and associated procurement, probity and contracting processes;

d) review and recommend to the Board the approval or otherwise of expenditure on development and construction projects and associated business cases;

e) approve expenditure and procurement within existing budgets, capex and operational funds, in accordance with the CMDHB Delegated Financial Authority Policy, for the purposes of carrying out the committee’s functions and administering the preliminary investigation fund;

f) liaise closely with the CEO in relation to facilities management and planning to assist the CEO to implement the Board’s strategic intentions for building and infrastructure assets;

 g) work closely with the CEO, ARF and HAC committees to ensure that there are clear responsibilities for approval and monitoring of major capital works development and management; and

h) support the development of a quality improvement culture.
3 Responsibilities

3.1 To carry out its functions the Committee will:

a) control and oversee a preliminary investigation fund established for the purpose of investigating the feasibility and defining the scope, estimated cost and desirability of potential capital and development projects;

b) commission and receive reports from CMDHB management relating to capital and development projects;

c) monitor the development, progress, conclusions and recommendations of business cases proposing major new capital and provider arm development projects;

d) consider all such projects and either:
   i) approve or reject any such projects that are within the funding levels delegated by the Board, on such conditions as the Committee believes are appropriate; or
   ii) refer any such projects above the delegated funding authority to the Board for approval or rejection;

e) closely monitor and review the progress of any approved projects against both the project execution plan and the budget provision and time programme;

f) monitor project risks and application of risk mitigation strategies including minimising disruption to services, mitigating risk of harm to staff and public (e.g. health and safety);

g) commission independent adviser reports related to the projects or other relevant matters as it sees fit and convey the substance of such reports to the Board where concerns make this appropriate; and

h) carry out any other activities required for the Committee to properly fulfil the above functions and responsibilities.

i) carry out any other activities required for the Committee to properly fulfil the above functions and responsibilities.

4 Accountability

4.1 The Committee is accountable to the Board of the CMDHB.

4.2 The Committee is advisory only, except to the extent that authority to make decisions and approve expenditure is specifically delegated to the Committee by resolution of the Board.

4.3 Any recommendations or decisions of the Committee must be ratified by the CMDHB Board (unless authority has already been delegated to the Committee).

4.4 The Committee may only give advice or release information to other parties under authority from the Board of the CMDHB.
4.5 The Committee is to comply with the provisions of the New Zealand Public Health and Disability Act 2000 and the standing orders of CMDHB.

5 Committee Membership

5.1 The Committee will comprise 5 members of the Board including Chair, Chair of HAC and Chair of ARF and 2 other members.

5.2 The Board will appoint the Committee members, Chair and Deputy Chair.

5.3 The Board or Committee may co-opt additional attendees with expertise relevant to the Committee’s function. The Board must agree the membership of independent members.

5.4 All Committee members are bound by the Act and CMDHB standing orders, whether or not they are CMDHB Board members or external attendees.

6 Quorum

6.1 A quorum will be 3 members of the Committee with Board members forming the majority.

7 Frequency of Meetings

7.1 The Committee shall meet as frequently as required beginning with quarterly.

8 Management Support

8.1 The Director, Population Health and Strategy will arrange management and administrative for the Committee.
Recommendations

It is recommended that the Board:

Approve the establishment of the Alice Nelson Charitable Trust on the terms of the trust deed attached and with the assets as described in the background section of this paper.

Approve the appointment of Jenny Parr, Director of Patient Care, Chief Nurse & Allied Health Professions Officer as a trustee of the Alice Nelson Charitable Trust.

Note that the two approvals above are subject to final approval by the Minister of Health.

Note that this paper has been shared with WDHB & ADHB. On 23 May 2018, the Board of ADHB noted the proposed establishment of the Trust and, subject to Minister of Health approval, approved the appointment of its Chief Nursing Officer as a trustee of the Trust. WDHB’s response is pending.

Note that the Audit Risk & Finance Committee directed management to investigate options for increasing the capital and inflation protection mechanisms for the Trust prior to submitting the proposal to Board for consideration. The proposed approach for increasing such protection is outlined in this paper and reflected in the Opening Trustee Resolutions attached to this paper.

Prepared and submitted by: Prepared by Karli Menary – Legal Adviser and endorsed by Margaret White, Chief Financial Officer.

Purpose

The purpose of this paper is to seek approval for:

(a) the establishment of the Alice Nelson Charitable Trust; and
(b) the appointment of Jenny Parr, Director of Patient Care, Chief Nurse & Allied Health Professions Officer as a trustee of the Alice Nelson Charitable Trust.

Executive Summary

CMDHB proposes to establish a charitable trust in the name of Alice Nelson, the late Edward Nelson’s mother, for charitable purposes that include providing financial assistance to nurses, midwives and their families in Auckland in financial need.

Once the Alice Nelson Charitable Trust (the Trust) is established, CMDHB plans to transfer approximately $1,950,000, representing the proceeds of sale of 18 The Parade, Bucklands Beach, Auckland (the Property) which was bequeathed to one of its predecessor organisations under the will of Edward Nelson dated 1973, less agreed costs (the net amount being the Funds), to the Trust.

Once the Trust has been established and the Funds have been transferred to the Trust, the trustees of the Trust will become responsible for the management and distribution of the Funds in accordance with the terms of the deed establishing the Trust, as drafted by Chapman Tripp (the Trust Deed).
CMDHB has approval from the Attorney-General to establish the Trust as per the Trust Deed. This approval is attached as Appendix 1. Once approvals from CMDHB, the Auckland District Health Board (ADHB) and the Waitemata District Health Board (WDHB) are provided with respect to establishing the Trust and the appointment of specific trustees, final approval from the Minister of Health will be sought.

Background

By will dated 5 December 1973 (the Will), Mr Edward Victor Nelson bequeathed the Property to the Auckland Hospital Board (the AHB) to be used as a convalescent or rest home for nurses in the Auckland region. The Property was transferred to the AHB in accordance with the Will in 1982.

In 1982, the AHB transferred the Property to the Auckland Nurses and Midwives Rest and Recreation Society Incorporated (the Society) (then known as the Auckland School of Nursing Rest and Recreation Society Incorporated) for the purpose of providing convalescent and rest home services for members of the nursing staff of the AHB, pursuant to the AHB’s obligation under the Will. The Property transfer was made pursuant to an agreement dated 25 June 1982 (the Transfer Deed). The Transfer Deed specified that:

(a) The Society was to use the Property to provide convalescent and rest home services for nursing staff of the AHB;

(b) If, at any stage, the Society was unable or unwilling to provide these services, the Property was to be transferred back to the AHB; and

(c) The AHB was to pay the maintenance costs of the Property.

In 2014, the Society decided that it could no longer effectively use the Property to provide convalescent and rest home services and, accordingly, wished to divest itself of the Property. CMDHB then obtained approval from ADHB and the WDHB to:

(a) sell the Property and apply the proceeds for an appropriate purpose close in nature to the terms of the original bequest, as approved by the Attorney-General;

(b) seek reimbursement from the proceeds of sale of all costs directly incurred by CMDHB in obtaining the appropriate approvals, disposing of the Property and establishing a subsequent trust mechanism to give effect to the testator’s wishes; and

(c) pay the Society compensation for all improvements of a permanent nature made to the Property (as per CMDHB’s obligation to do so under clause 4 of the Transfer Deed).

Approval in principle was received in June 2014 by the then Minister of Health that the Property could be sold by CMDHB pursuant to section 11A of the Health Sector (Transfers) Act and the proceeds of sale held to further the intent of the original bequest. The Property was sold in August 2015. The funds are held by CMDHB in a sub-account established specifically to hold these trust funds.

CMDHB consulted with the Society and determined that the Funds would be more prudently managed and Mr Nelson’s original wishes served if the Funds were held in a charitable vehicle with a more representative board of trustees. There was a concern that the membership base of the Society narrowed the number and class of persons who may potentially benefit from the Funds.

In order to establish the Trust, approval is required from the Attorney-General, the three Boards (CMDHB, ADHB and WDHB), and the Minister of Health. Chapman Tripp prepared the Trust Deed and a letter to the Minister of Health, which was copied to the Attorney-General. The Attorney-General referred the letter to Crown Law, who replied to Counties DHB in a letter dated 23 December 2016. Since then, there has been on-going correspondence between Crown Law and Chapman Tripp regarding
queries and amendments to the Trust Deed. The Attorney-General approved CMDHB’s proposal to establish the Trust, along with the draft Trust Deed on 3 December 2017. The Attorney-General approval is attached to this paper as Appendix 1 and the Trust Deed is attached to this paper as Appendix 2.

The Ministry of Health has advised CMDHB to gain Board approval from CMDHB, ADHB and WDHB before requesting final approval from the Minister of Health.

Proposal

Establishment of the Trust

CMDHB proposes to establish the Trust for charitable purposes that include providing financial assistance to nurses, midwives, and their families in Auckland in financial need. It is proposed that the Funds be transferred from CMDHB to the Trust upon which the trustees of the Trust become responsible for the management and distribution of the Funds in accordance with the terms of the Trust Deed.

It is proposed that at their first meeting the Trustees will be asked to discuss, and subsequently agree, a policy on capital protection which will then guide them and all subsequent Trustees in their dealing with and protection of capital. They will also be asked to develop a Statement of Investment Policy that defines the makeup of the investment portfolio they intend to hold. This proposal is reflected in the Opening Trustee Resolutions attached as Appendix 3.

The establishment of the Trust satisfies the requirements of section 28 of the New Zealand Public Health and Disability Act 2000, subject to the final consent of the Minister of Health.

Appointment of trustees of the Trust

As per clause 8.3 of the Trust Deed, each of the nominating bodies (being the Society, CMDHB, WDHB and ADHB) has the power to nominate one trustee for appointment. CMDHB proposes to appoint Jenny Parr, Director of Patient Care, Chief Nurse & Allied Health Professions Officer as a trustee of the Trust. Holding the most senior nursing position within CMDHB, Ms Parr is a well-respected in the nursing community and is well-placed to ensure that the funds are managed in accordance with the purposes of the Trust. As mentioned above, the final consent of the Minister of Health is required under section 28 of the New Zealand Public Health and Disability Act 2000 before this nomination can be finalised.

During the establishment phase, CMDHB will collaborate with the Trust to identify and implement governance training opportunities to support its nominated Trustee.

Deduction of costs

CMDHB will compensate the Society for improvements made to the Property in the amount of $25,000. That figure was arrived at following a valuation of the Property and estimation of the funds spent by the Society in improving it. In addition, CMDHB has agreed to reimburse the Society for certain maintenance and upkeep costs paid in connection with property ($8,350) and for the legal fees it incurred in connection with the sale of the property ($3,500). CMDHB has itself incurred approximately $37,000 of legal fees to one legal service provider (mainly relating to the sale of the property) and $22,000 to Chapman Tripp (relating to the establishment of the Trust).

The aggregate of all of these costs will be deducted from the proceeds of sale of the Property prior to the net amount (i.e. the Funds) being transferred to the trustees of the Trust.
Registration of Trust as a charity

Once the Trust Deed has been executed, the trustees will apply for registration as a charity under the Charities Act 2005 and incorporation as a charitable trust board under the Charitable Trusts Act 1957. Following completion of those formalities, CMDHB would settle the Funds onto the trustees for them to administer going forward. The draft Opening Trustee Resolutions attached as Appendix 3 have been structured to assist the Trustees at this establishment phase.

Next Steps

Once approvals from CMDHB, ADHB and WDHB are provided with respect to establishing the Trust and the appointment of specific trustees, final approval from the Minister of Health will be sought. The Ministry of Health is aware that CMDHB will making this request and have provided input into various aspects of the proposal and process to date.

Appendices

1: Attorney-General approval
2: Draft Trust Deed of the Alice Nelson Charitable Trust (as approved by the Attorney-General)
3: Draft Opening Trustee Resolutions.
APPROVAL UNDER S 11A OF THE HEALTH SECTOR (TRANSFERS) ACT 1993

WHEREAS a trust, consisting of a property at 18 The Parade, Bucklands Beach, Auckland, to be operated as a convalescent home for Auckland nurses, was created by the will of Edward Victor Nelson dated 5 December 1973;

AND WHEREAS that property has been sold, and the proceeds are held on trust by the Counties Manukau District Health Board;

AND WHEREAS the Counties Manukau District Health Board have sought the Attorney-General's approval under s 11A of the Health (Transfers) Act 1993 to transfer the trust property to the Alice Nelson Charitable Trust;

NOW I, David Parker, Attorney-General, having determined that the Alice Nelson Charitable Trust is a similar trust to the Nelson Will Trust, approve the transfer of the trust property to the Alice Nelson Charitable Trust, under s 11A of the Health (Transfers) Act 1993.

DATED at Wellington this 31 day of November 2017

Hon David Parker
Attorney-General
Alice Nelson Charitable Trust

Counties Manukau District Health Board (the Settlor)

[Names] (the Trustees)
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**SCHEDULE 2: BRASS PLATE**

**EXECUTION**
ALICE NELSON CHARITABLE TRUST

Date: 

PARTIES

Counties Manukau District Health Board (the Settlor)

[Names] (the Trustees)

BACKGROUND

A The late Mr Edward Victor Nelson left a bequest under his will dated 1973 to the then Auckland Hospital Board on the condition that his late mother, Alice Nelson, be recognised in relation to the gift. The Settlor has succeeded to the bequest and now intends to settle it upon a charitable trust in the name of Alice Nelson and in furtherance of the original charitable intent of Mr Edward Nelson adapted to modern day purposes.

B The Settlor is in possession of a brass plate made to commemorate Alice Nelson.

C On signing this deed, the Settlor has paid $10 and transferred the brass plate mentioned above to the Trustees to be held upon the trusts and with the powers set out in this deed. It is intended that, following the registration of the Trust the Settlor will transfer the funds representing the bequest less agreed costs to the trustees to hold on the terms of this trust deed.

NOW THIS DEED RECORDS:

1 DEFINITIONS AND CONSTRUCTION

1.1 Defined terms

In this deed, unless the context requires otherwise:

Balance Date means 31 March or any other date which the Trustees adopt by resolution as the date up to which accounts are to be made in each year;

Brass Plate means the brass plate made to commemorate Alice Nelson which formerly hung in the home of her son, Mr Edward Victor Nelson, at 18 The Parade, Bucklands Beach, Auckland, a photo of which is attached in Schedule 2;

Designated Gift means a gift which is subject to a trust for a specific purpose that comes within the purposes of the Trust Fund;

Income Year means any year or other accounting period ending on a Balance Date;

Nominating Body means the organisations listed in clause 8.3(a) to (d) and includes their successors;
Nurses and Midwives means, for the purposes of clause 4, any person who is or has been:

(a) a nurse registered with the Nursing Council of New Zealand; or

(b) a midwife registered with the Midwifery Council of New Zealand,

in each case who has worked in the area covered by the Waitemata, Auckland or Counties Manukau District Health Boards (or their predecessors or successors) and currently resides in that area;

Related Person for the purposes of clause 15.2 and in relation to any business to which section CW42(5) of the Income Tax Act 2007 applies, means a person specified in paragraphs (i) to (iv) of subsection (5)(b) of that section, the persons currently specified being:

(c) a settlor or trustee of the trust by which the business is carried on; or

(d) a shareholder or director of the company by which the business is carried on; or

(e) a settlor or trustee of a trust that is a shareholder of the company by which the business is carried on; or

(f) a person associated with a settlor, trustee, shareholder or director already mentioned in this definition;

Teleconference Meeting means a meeting where the participants are contemporaneously linked by telephone or some other means of instant audio or audio and visual communication;

Trust means the charitable trust created by this deed;

Trust Fund means the sum of $10 and the Brass Plate referred to in Background C of this deed and includes any money, investments or other property paid or given to or acquired or agreed to be acquired by the Trustees after this deed has been signed with the intention that it be held by the Trustees subject to the trusts and other provisions set out in this deed.

1.2 Construction

In the construction of this deed, unless the context requires otherwise:

(a) a reference to "this deed" is a reference to this deed as amended from time to time;

(b) a reference to "Trustees" is a reference to the trustees for the time being of the Trust Fund, whether original, additional or substituted;

(c) a reference to a person includes a corporation sole and also a body of persons, whether corporate or unincorporate;
ALICE NELSON CHARITABLE TRUST

(d) a reference to an enactment is a reference to that enactment as amended, or to any enactment that has been substituted for that enactment;

(e) the Schedule forms part of this deed;

(f) headings appear as a matter of convenience and shall not affect the construction of this deed.

2 CREATION OF THE TRUST

2.1 Declaration of trust
The Settlor directs, and the Trustees acknowledge, that the Trustees shall hold the Trust Fund upon the trusts and with the powers and for the purposes set out in this deed.

2.2 Name of trusts
The trusts created by this deed are to be known as the “Alice Nelson Charitable Trust” or by such other name as the Trustees may determine by resolution from time to time, provided that it is intended that the name ‘Alice Nelson’ never be removed from the name.

3 REGISTRATION

3.1 Incorporation under the Charitable Trusts Act 1957
The Trustees may apply under the Charitable Trusts Act 1957 for incorporation as a Board under the name Alice Nelson Charitable Trust, or under such other name approved by the Registrar of Incorporated Societies.

3.2 Registration under the Charities Act 2005
If they consider it appropriate the Trustees or the Board (as the case may be) may apply to be registered as a charitable entity under the Charities Act 2005. If and while so registered, the Trustees or the Board (as the case may be) will comply with the requirements of that Act.

4 PURPOSES

4.1 The Trust is established for the following purposes:

(a) to provide financial and other assistance to Nurses and Midwives who have a need for such assistance whether through age, physical or mental ill-health, accident or disability;

(b) to provide financial and other assistance to Nurses and Midwives and/or their families in financial need; and

(c) for any other charitable purposes within New Zealand that are similar in nature to the specific purposes of the Trust (whether these be nursing related, or charities for the relief of the aged and the ill or those in financial need) and which are charitable according to the law of New Zealand.
4.2 The intention is that clause 4.1(a) is the primary charitable purpose of the Trust and that clauses 4.1(b) and 4.1(c) are secondary charitable purposes. Notwithstanding this, the Trustees may further any of the purposes in clause 4.1 at any time, including 4.1(b) and/or 4.1(c) ahead of 4.1(a), if in their absolute discretion they consider it appropriate.

5 **INCOME TRUSTS**

5.1 **Power to pay, apply or appropriate income**

The Trustees may pay, apply or appropriate, or decide to pay, apply or appropriate as much of the income arising from the Trust Fund in an Income Year as they think fit for or towards one or more of the purposes of the Trust and if the Trustees so provide for more than one purpose they need not treat each purpose equally.

5.2 **Provisions relating to payments, applications and appropriations of income**

(a) The Trustees may appropriate any investments for one or more of the purposes of the Trust in anticipation of a payment or application under clause 5.1.

(b) In any Income Year, the Trustees may appropriate all or part of the income derived or to be derived from the Trust Fund during that Income Year even though, at the time of appropriation, they have not received the income being appropriated.

(c) If the Trustees appropriate any income for any purpose of the Trust the recipient of that income shall take an absolute and indefeasible interest in that income as from the date on which it is appropriated.

5.3 **Power to retain income**

The Trustees need not distribute all of the income arising from the Trust Fund in an Income Year, but may retain or decide to retain all or part of that income to establish or augment any reserve fund, which may be used at any later time for any purpose for which income arising from the Trust Fund may be used.

5.4 **Receipts for payments of income**

The receipt of the secretary, treasurer or other person or persons appearing to the Trustees to be authorised to give receipts on behalf of the recipient, of any payment of income made under clause 5.1, shall be a complete discharge to the Trustees for that payment.

6 **CAPITAL TRUSTS**

6.1 **Power to pay, apply or appropriate capital**

At any time the Trustees may pay, apply or appropriate or decide to pay, apply or appropriate as much of the capital of the Trust Fund as they think fit for or towards one or more of the purposes of the Trust and if the Trustees so provide for more than one purpose they need not treat each purpose equally.

6.2 **Provisions relating to payments, applications and appropriations of capital**

(a) Any payment, application or appropriation of capital may be made either in addition to, or in place of, any payment, application or appropriation of income.
(b) The Trustees may appropriate any investments for one or more of the purposes of the Trust in anticipation of a payment or application under clause 6.1.

6.3 **Receipts for payments**
The receipt of the secretary, treasurer or other person or persons appearing to the Trustees to be authorised to give receipts on behalf of the recipient, of any payment of capital made under clause 6.1, shall be a complete discharge to the Trustees for that payment.

7 **RECEIPT OF GIFTS**

7.1 **Receipt of gifts**
The Trustees may receive solicited and unsolicited gifts of any real or personal property for the purposes of the Trust or for any specific purpose that comes within the purposes of the Trust.

7.2 **Separate specific trusts**
(a) If the Trustees accept a Designated Gift they must keep that Designated Gift and any income derived from it separate from the general assets of the Trust Fund, and administer it as a separate specific trust in terms of the trust under which it was given.

(b) The Trustees shall not use the assets of any separate specific trust to make good any deficit, loss, damage or breach of trust relating to any other separate specific trust.

(c) Each separate specific trust shall bear its own administration expenses plus a fair proportion (determined by the Trustees) of the administration expenses applicable to the general purposes of the Trust.

7.3 **Trustees may refuse a gift**
The Trustees may refuse to accept any gift if they determine that it is in the best interests of the Trust to do so.

8 **TRUSTEES**

8.1 **Number of Trustees**
There shall be no fewer than four, nor more than eight Trustees at any time and if the Trustees number less than the minimum number of Trustees the person or persons having the statutory power to appoint new Trustees must promptly appoint such new Trustees.

8.2 **Appointment of new and additional Trustees**
The statutory power of appointment of Trustees shall be vested in the Trustees, but if at any time there are no Trustees then the power shall be vested in the President for the time being of the New Zealand Law Society.

8.3 **Nominating Bodies**
Each of the following Nominating Bodies or their successors has the power to nominate for appointment one Trustee:
(a) The Auckland Nurses and Midwives Rest and Recreation Society Incorporated;
(b) The Counties Manukau District Health Board;
(c) The Waitemata District Health Board;
(d) The Auckland District Health Board,

provided that if any of the Nominating Bodies ceases to exist without leaving an appropriate successor (such decision as to an appropriate successor to be taken by the other Trustees) then the opportunity of that Nominating Body to nominate a person to be appointed a Trustee shall also cease.

8.4 Nomination
The means by which a nominee of the Nominating Bodies shall be appointed shall be as follows:

(a) Once the Trustees become aware of an existing or future vacancy they will notify the relevant Nominating Body of the need to put forward a nominee and the necessary timeframe;

(b) The relevant Nominating Body shall determine, in accordance with its internal processes, the name of the nominee to be put forward, having obtained that person’s consent, and shall notify the Trustees of the name of the nominee;

(c) The other Trustees shall appoint such nominee as a Trustee.

8.5 Other Trustees
The Trustees shall also be able to appoint Trustees not nominated by Nominating Bodies, subject to clause 8.1.

8.6 Term of office
A Trustee shall hold office for a term not exceeding three years from the date of appointment but shall be eligible for re-appointment for a further term or terms up to a maximum of three terms in total.

8.7 Quorum
A majority of Trustees shall constitute a quorum at meetings of the Trustees.

8.8 Termination of office
A Trustee shall cease to hold office if he or she:

(a) retires from office by giving written notice to the Trustees or the secretary of the Trust;

(b) completes his or her term of office without being reappointed;

(c) refuses to act;

(d) is absent without leave from 3 consecutive ordinary meetings of the Trustees;
(e) becomes physically or mentally incapacitated to the extent that in the opinion of the other Trustees, expressed in a resolution, he or she is unable to perform the duties of a Trustee properly;

(f) ceases to qualify as an officer of a charitable entity under section 16 of the Charities Act 2005; or

(g) in the opinion of the other Trustees expressed in a resolution, is for any other reason unfit to carry out the duties of a Trustee.

8.9 **Record of changes of Trustees**
Upon every appointment, retirement, re-appointment or termination of office of any Trustee the Trustees will ensure that an entry is made in the minute book of the Trust to that effect and that any statutory requirements as to the vesting of the Trust Fund in the Trustees are satisfied.

8.10 **Validity of Proceedings**
Where, for any reason, a Trustee is not properly appointed or is disqualified from holding office, anything done by that Trustee (or by a meeting at which that Trustee was present as a Trustee) before discovery of the irregularity, shall be as valid as if that Trustee had been duly appointed or had not been disqualified (as the case may be).

8.11 **Appointment of chairperson**
The Trustees may elect one of their number as a chairperson to chair their meetings. If the chairperson cannot be present, or is not present within 10 minutes of the time appointed for any meeting, the Trustees present may elect one of their number to be the chairperson of the meeting. The chairperson shall not have a casting vote in the event of the voting being declared even.

8.12 **Appointment of secretary and others**
The Trustees may appoint a secretary and any other officers or employees that the affairs of the Trust may require on such terms and conditions as they think fit. The Trustees may also remove and replace any persons so appointed.

8.13 **Committees**
The Trustees may appoint sub-committees, ad hoc committees or executive committees as they may from time to time think expedient for carrying out the purposes of the Trust. Any such committee may co-opt any other person, whether a Trustee or not, to be a member of that committee. Subject to any directions that the Trustees might give, each committee may regulate its own procedure.

9 **TRUSTEE MEETINGS**

9.1 **Meetings**
The Trustees shall meet as often as they consider desirable for the efficient and proper conduct of the affairs of the Trust, but in any event at least once in each Income Year.
9.2 **Notice of meetings**
(a) Written notice of every meeting of Trustees shall be either hand-delivered, posted or sent by facsimile or email to each Trustee at least 7 days before the date of the meeting.

(b) Every notice of a meeting shall state the place, day and time of the meeting and may also state the subject-matter of the meeting.

(c) The requirement for notice of a meeting may be waived if all the Trustees give their consent to such a waiver.

9.3 **Adjournment**
If a quorum is not present within 30 minutes after the time appointed for any meeting the Trustee or Trustees present may adjourn the meeting.

9.4 **Resolutions**
(a) Except where this deed provides otherwise a decision is taken and a resolution is validly made when it is passed by a simple majority of those Trustees present and entitled to vote at a duly convened and conducted meeting of the Trustees.

(b) The Trustees may vary or cancel any resolution at a meeting.

(c) A written resolution signed by all the Trustees shall be as effective for all purposes as a resolution passed at a properly convened and conducted meeting of the Trustees. Such a resolution may comprise several duplicated documents, each signed by one or more of the Trustees.

9.5 **Minutes**
(a) The Trustees shall keep a proper record in a minute book of all decisions taken and business transacted at every meeting of the Trustees.

(b) Where minutes of the proceedings at a meeting of the Trustees have been made in accordance with the provisions of this rule then, until the contrary is proved, the meeting shall be deemed to have been properly convened and its proceedings to have been properly conducted.

9.6 **Teleconference Meetings**
(a) A Teleconference Meeting between a number of Trustees who constitute a quorum, shall be deemed to constitute a meeting of the Trustees. All the provisions in this deed relating to meetings shall apply to Teleconference Meetings so long as the following conditions are met:

(i) All of the Trustees for the time being entitled to receive notice of a meeting shall be entitled to notice of a Teleconference Meeting and to be linked for the purposes of such a meeting. Notice of a Teleconference Meeting may be given on the telephone;

(ii) Throughout the Teleconference Meeting each participant must be able to hear each of the other participants taking part;
(iii) At the beginning of the Teleconference Meeting each participant must acknowledge his or her presence for the purpose of that meeting to all the others taking part;

(iv) A participant may not leave the Teleconference Meeting by disconnecting his or her telephone or other means of communication without first obtaining the consent of the chairperson, or if there is no chairperson, the consent of the other participants. Accordingly, a participant shall be conclusively presumed to have been present and to have formed part of the quorum at all times during the Teleconference Meeting unless he or she leaves the meeting with such consent;

(v) A minute of the proceedings at the Teleconference Meeting shall be sufficient evidence of those proceedings, and of the observance of all necessary formalities.

10 **AUDIT, ANNUAL REPORT AND FINANCIAL STATEMENTS**

10.1 At their first meeting in each Income Year (other than the first Income Year) the Trustees shall present a report dealing with the affairs of the Trust, supported by a statement of the Trust’s income and expenditure during the previous Income Year and a statement of its assets and liabilities at the end of that Income Year.

10.2 The Trustees will ensure that they comply with current reporting standards and requirements for an entity with the level of expenditure of the Trust.

10.3 If the Trustees at any time resolve to appoint an auditor to audit or reviewer to review the Trust’s financial statements then they will ensure that the financial statements of the Trust for each Income Year are audited or reviewed, as the case may be, by a chartered accountant in public practice within 4 months after the end of that Income Year. The person appointed as auditor or reviewer must not be a Trustee.

11 **CONTROL OF FUNDS**

All money received by or on behalf of the Trust shall be paid immediately to the credit of the Trust in an account or accounts with a Bank or Banks selected from time to time by the Trustees. All cheques and other negotiable instruments, withdrawal slips and receipts for money shall be signed, drawn, accepted, endorsed or otherwise executed (as the case may be) on behalf of the Trust in such manner as the Trustees decide from time to time.

12 **CUSTODY AND USE OF COMMON SEAL**

If the Trustees become incorporated as a Board under the Charitable Trusts Act 1957 they shall adopt a common seal and have custody of the common seal. The common seal may be affixed to any document only with the prior authorisation of the Trustees and, once authorised, may be affixed in the presence of any two Trustees who must sign the document.
13 Disclosures of Interests

13.1 Interested Trustee
(a) A Trustee will be interested in a matter in which the Trust is involved if the Trustee:

(i) is a party to, or will derive a material financial benefit from a transaction with the Trust;

(ii) has material financial interest in another party to a transaction with the Trust;

(iii) is a director, officer or trustee of another party to, or person who will or may derive a material financial benefit from a transaction with the Trust, not being a party that is wholly owned by the Trust;

(iv) is the parent, child or spouse of a person who will or may derive a material financial benefit from a transaction with or distribution from the Trust; or

(v) is otherwise directly or indirectly interested in a matter involving the Trust.

(b) As soon as a Trustee becomes aware of the fact that he or she is interested in a matter involving the Trust, he or she must disclose to his or her co-trustees:

(i) the nature and monetary value of that interest (if the monetary value of the Trustee’s interest is able to be quantified); or

(ii) if the monetary value of the Trustee’s interest cannot be quantified, the nature and extent of that interest.

(c) A disclosure of interest by a Trustee must be recorded in the minute book of the Trust.

13.2 Interested Trustee may not vote
A Trustee who is interested in a matter involving the Trust may not vote on a decision relating to that matter, nor be included among the Trustees present at the meeting for the purpose of determining a quorum, but may:

(a) attend a meeting of Trustees at which discussion of the matter arises;

(b) sign a document relating to the matter on behalf of the Trust; and

(c) do anything else as a Trustee in relation to the implementation of the matter, as if he or she were not interested.

13.3 Dealing with interested Trustees
Subject to clauses 13.1 and 13.2, each Trustee may act as a Trustee and still contract or otherwise deal with the Trustees in his or her personal capacity or in any other capacity as if he or she had not been appointed as a Trustee.
14  **RESTRICTIONS ON PRIVATE PECUNIARY PROFIT AND ON BENEFITS IN BUSINESS ACTIVITY**

14.1  **No private pecuniary profit of any individual and exceptions**

(a)  No private pecuniary profit shall be made by any person involved in this Trust, except that:

(i) any Trustee or committee member appointed by the Trustees shall be entitled to be reimbursed out of the assets of the Trust for all expenses which he or she properly incurs in connection with the affairs of the Trust;

(ii) the Trust may pay reasonable and proper remuneration to any officer or servant of the Trust (but not a Trustee acting in that Trustee capacity) in return for services actually rendered to the Trust;

(iii) any Trustee is to be paid all usual professional, business or trade charges for services rendered, time expended and all acts done by that Trustee or by any firm or entity of which that Trustee is a member, employee or associate in connection with the affairs of the Trust;

(iv) any Trustee may retain any remuneration properly payable to that Trustee by any company or undertaking with which the Trust may be in any way concerned or involved for which that Trustee has acted in any capacity whatever, notwithstanding that that Trustee’s connection with that company or undertaking is in any way attributable to that Trustee’s connection with the Trust.

(b)  The Trustees, in determining all reimbursements, remuneration and charges payable in terms of this clause, shall ensure that the restrictions imposed by this clause 14.1 are strictly observed.

14.2  **Prohibition of benefit or advantage in business activity**

(a)  In the carrying on of any business under this deed no benefit, advantage or income shall be afforded to, or received, gained, achieved or derived by any Related Person where that Related Person, in his or her capacity as a Related Person, is able in any way (whether directly or indirectly) to determine, or to materially influence the determination of:

(i)  the nature or amount of that benefit, advantage or income; or

(ii) the circumstances in which that benefit, advantage or income is, or is to be, so afforded, received, gained, achieved or derived.

(b)  A person who is in the course of, and as part of the carrying on of his or her business of a professional public practice, shall not, by reason only of him or her rendering professional services to the Trust or to any company by which any business of the Trust is carried on, be in breach of the terms of this clause 14.2.
15 **TRUSTEES’ POWERS**

15.1 **General power**

It is intended that in the exercise of their discretion the Trustees shall have the fullest possible powers in relation to the Trust Fund, and that they may do anything they think necessary, expedient or desirable in furtherance of the purposes of the Trust. However:

(a) this general power does not authorise the Trustees to do anything which may prejudice the charitable nature of the purposes of the Trust; and

(b) all the Trustees’ powers, authorities and discretions shall be subject to any direction to the contrary in any instrument evidencing or conferring a gift accepted by the Trustees, whether the gift is a Designated Gift or is generally for the purposes of the Trust Fund.

15.2 **Specific powers**

Without prejudice to the generality of clause 15.1, or to any of the Trustees’ express or implied powers, the Trustees shall have the powers specified in the Schedule and may exercise them either alone or with any other person(s) in furtherance of the purposes of the Trust.

16 **ADVICE OF COUNSEL**

If the Trustees are in doubt over any matter relating to the administration of the Trust Fund, or over the exercise of any power vested in them, they may obtain and act upon the opinion of a barrister of the High Court of New Zealand of at least 7 years’ standing. And they may act upon the barrister’s opinion without being liable to any person who may claim to be beneficially interested in respect of anything done in accordance with that opinion. This right to obtain and act upon a barrister’s opinion, however, will not restrict the Trustees’ right to apply to the High Court of New Zealand for directions.

17 **LIABILITY OF TRUSTEES**

17.1 **Liability for loss**

A Trustee shall be liable only for any loss attributable to his or her dishonesty or to his or her wilful commission or omission of an act which he or she knows to be a breach of trust. In particular, no Trustee shall be bound to take, or liable for failing to take, any proceedings against a co-Trustee for breach or alleged breach of trust.

17.2 **Standard of care**

Where, for the time being, there is more than one person acting as a trustee of the Trust Fund, and one or more, but not all, of them is or are engaged in a profession, employment or business which is or includes acting as a trustee or investing money on behalf of others, then in exercising any power of investment, that trustee or those trustees (as the case may be) shall not be required to exercise the care, diligence and skill that a prudent person engaged in that profession, employment or business would exercise in managing the affairs of others. Rather, that trustee or those trustees (as the case may be) shall be required only to exercise the care, diligence
and skill that a prudent person of business would exercise in managing the affairs of others. This clause 17.2 shall constitute a contrary intention for the purposes of clause 13D of the Trustee Act 1956.

18 **TRUSTEE INDEMNITY**

A Trustee shall be entitled to exoneration and indemnity out of the assets of the Trust for any liability which that Trustee incurs in relation to the Trust and which is not attributable to that Trustee’s dishonesty or to his or her wilful commission or omission of an act which he or she knows to be a breach of trust.

19 **WINDING UP**

19.1 The Trustees may only wind up the Trust if:

(a) the Trust has no assets and has ceased to operate; or

(b) in any other situation, only with the approval of the Court.

19.2 On the winding up of the Trust under clause 19.1(b) and subject to any direction otherwise from the Court, the Trustees must give or transfer all surplus assets after the payment of costs, debts and liabilities:

(a) to some other charitable organisation or body within New Zealand having similar objects to the Trust; or

(b) if no such organisation exists with a satisfactory reputation or track record, for some other charitable purpose or purposes within New Zealand.

20 **ALTERATIONS TO DEED**

20.1 Subject to clauses 20.2 and 20.3, this deed (including the Schedule) may be altered only by:

(a) a resolution of Trustees passed at a meeting of Trustees of which written notice specifying the nature of the proposed alteration has been provided to each Trustee at least 7 days before the date of the meeting at which it is to be considered; or

(b) a written resolution of Trustees under clause 9.4(c).

20.2 No alterations can be made to clauses 4.1, 4.2 (charitable purposes) or clause 19 (winding up).

20.3 Any alteration to this deed that prejudices the charitable nature of the Trust, and in particular the meeting, by the Trust, of all the requirements for any exemptions available to charities under the New Zealand revenue laws, shall be invalid.
(Schedule follows)
SCHEDULE 1: TRUSTEES’ SPECIFIC POWERS

Pursuant to clause 15.2, the Trustees have the following specific powers:

1. **To raise funds**
   To raise money for any of the purposes of the Trust by all lawful means, including the conduct of fundraising campaigns.

2. **To invest**
   2.1 To invest the Trust Fund and the income from it in any form of investment on such terms and for such periods as the Trustees in their absolute discretion determine, and to vary any such investment from time to time.

   2.2 To hold one or more investments without any obligation to diversify, or to consider diversifying, between investments or nature or types of investment and without being liable for any resultant loss to the Trust Fund.

   2.3 To hold a single investment or to concentrate their capital investment in any single asset (including, but without limitation, shares in a company or group of companies) without being liable for any resultant loss to the Trust Fund.

3. **To appoint an investment manager**
   3.1 To appoint any person as an investment manager to invest and manage all or any investments forming part of the Trust Fund on such terms as the Trustees think fit, such terms to include a regular review of the investment manager’s management of the investments.

4. **To retain investments**
   To retain any investments coming into the Trustees’ hands as part of the Trust Fund for as long as the Trustees think proper, even if they are not investments which could be properly made by a trustee.

5. **To sell**
   To sell any real or personal property forming part of the Trust Fund in the manner and on the terms and conditions the Trustees think fit, including (without limitation) power to allow such part of the purchase price as the Trustees think fit to remain on loan with or without security or to be payable by instalments.

6. **To postpone sale**
   To postpone the sale of any real or personal property forming part of the Trust Fund for as long as the Trustees think fit without being liable for any resultant loss to the Trust Fund.

7. **To let**
   To let any real and personal property at such rent and on such terms and conditions (including an option to purchase) as the Trustees think fit and to accept surrenders of any leases and tenancies.
8  **To borrow**  
To borrow any money at whatever rate of interest and upon whatever other terms and conditions the Trustees may think fit. For this purpose the Trustees may give security for repayment over the entire Trust Fund or any part of it, whether or not any part over which the security is given benefits from the borrowing.

9  **To carry on business**  
9.1  To carry on any business, whether in partnership or otherwise, for as long as the Trustees think fit. They may use any part of the Trust Fund as capital in the business, and may also employ in the business such managers, agents, employees and other persons (including any Trustee other than anyone who for the time being is the sole Trustee of the Trust Fund) as they think fit.

9.2  The Trustees shall be absolutely indemnified out of the Trust Fund for any losses which they may sustain in so carrying on any such business.

9.3  Subject to the terms and conditions on which any business is carried on by the Trustees, the net annual profits from any business shall, at the Trustees’ discretion, be distributable as income in the Trustees’ hands without having to be first applied in making good any earlier business losses. Any business losses for any year, unless the Trustees decide otherwise, shall be borne by the capital of the Trust Fund and not recouped out of later profits.

10  **To accept payment in company securities**  
In the sale of any business to a company, to accept payment for all or part of the purchase price in ordinary deferred or preference shares (whether fully paid or partly contributory) or debentures or debenture stock of such company. In exercising this power the Trustees shall not be taken to be exercising a power of investment.

11  **To promote a company**  
To promote a company or companies for the purpose of acquiring any business or the assets of any business.

12  **To act in relation to certain companies**  
In respect of any company in which the Trust Fund holds or is the beneficial owner of shares, notes, stock or debentures:

12.1  to act as a director of the company and to receive and retain fees or other remuneration for so acting without having to account to the Trust Fund unless the Trustees otherwise require;

12.2  to provide out of the Trust Fund on such terms as the Trustees think fit further capital for the company either by way of advances, loans, deposits or otherwise (with or without security) or by taking further shares in the company, but only insofar as the Trustees are satisfied on reasonable grounds that the provision of such further capital will contribute to the ability of the Trustees to fulfil the charitable purposes specified in clauses 4.1 to 4.4;
12.3 to concur in the winding up, reconstruction or amalgamation of the company or in the modification of its regulations, on whatever terms the Trustees think fit; and

12.4 generally to act in relation to the company in whatever manner the Trustees consider to be in the best interests of the Trust Fund.

13 To subdivide
To subdivide any real property forming part of the Trust Fund and to meet the costs of subdivision out of the Trust Fund.

14 To maintain property
To maintain, manage and improve property which, or any interest in which, forms part of the Trust Fund, in whatever manner the Trustees think fit. For those purposes, the Trustees may pay and apply any of the capital and income of the Trust Fund as they think fit.

15 To develop
To spend any sums out of the capital or income of the Trust Fund the Trustees think fit in developing any real property forming part of the Trust Fund, and to do all things (including dedicating roads) which the Trustees consider necessary or desirable for the proper completion of the development.

16 To purchase property
To purchase as an asset of the Trust Fund any property or interest in property which the Trustees consider will benefit the Trust Fund. In exercising this power the Trustees shall not be taken to be exercising a power of investment.

17 To grant and acquire options
To grant acquire, dispose of and exercise any option to purchase, lease or exchange any interest in real or personal property of any value, whether the option is incidental to, or independent of, any sale, lease, exchange or other disposition. An option may be granted acquired or disposed of on such terms and conditions as the Trustees think fit, and in respect of a grant, may be granted at a price determined at the time of the grant or at such later date as the Trustees think fit. The Trustees shall not be personally liable for any loss arising from their exercise of this power and shall be indemnified accordingly out of the Trust Fund.

18 To make loans and advances
To make any loans or advances (with or without security) for any of the purposes of the Trust Fund in such manner and on such terms and conditions as the Trustees think fit.

19 Capital, income and blended funds
To determine whether any money is to be considered as capital or income, and which expenses should be paid out of capital and out of income respectively, and also to apportion blended funds. Each determination or apportionment shall be final and binding on all persons beneficially interested in the Trust Fund.
20 **Depreciation or replacement funds**
To set up and maintain any depreciation or replacement funds for any purpose the Trustees may consider advisable, and in this regard to determine in their discretion:

20.1 the amount of income to be credited from time to time to any of those funds;

20.2 whether those funds are income or capital.

21 **Bank accounts**
To open any bank accounts in any name(s) either on the Trustees own behalf or jointly with some other person(s), and to overdraw any such account with or without giving security. The Trustees may also make arrangements with any bank for any one or more of the following persons to operate on any of the Trustees’ accounts at that bank:

21.1 the Trustees; and

21.2 any delegate(s) named in writing by all the Trustees.

22 **To guarantee or indemnify**
To guarantee the liability of any person or corporation or provide an indemnity for the purposes of the Trust Fund and to give security in support of any such guarantee or indemnity, provided that any such guarantee or indemnity directly supports one or more of the charitable purposes of the Trust as set out in clause 4.

23 **To insure**
To insure any building or other insurable property to any amount up to its full insurable value, or at the Trustees' option, up to its full replacement value, against destruction or damage by fire, earthquake, fire following earthquake and such other risks as the Trustees think fit. The Trustees may pay the premiums out of income or capital as they think fit.

24 **To waive debts**
Without being liable for loss, to waive any debts due to the Trust Fund, either absolutely or on such terms as the Trustees think expedient, provided that the Trustees have first used all reasonable effort to recover the debt.

25 **To deposit funds**
To deposit all or part of the Trust Fund in any currency in a savings or other interest or non-interest bearing account with any bank, trust, company or other financial or investment institution in any jurisdiction in the world. In making any deposit the Trustees shall not be liable for any loss due to devaluation or any foreign exchange or other governmental restriction.

26 **To hold the Trust Fund uninvested**
To hold any part of the Trust Fund uninvested and in any currency for as long as the Trustees think fit without being liable for any loss due to devaluation or any foreign exchange or other governmental restriction.
27 **To protect or enhance assets**
To enter into any type of contract whatever to protect, maintain or enhance the value of any assets acquired or held by the Trustees or which they have the right to acquire or hold.

28 **To appoint officers or employees**
The Trustees may appoint persons as officers or employees (including Trustees) of the Trust if, in their opinion, the affairs of the Trust require such appointments, on such terms and conditions as they think fit. The Trustees may also remove and replace any person so appointed.

29 **To delegate collectively administrative functions**
To employ and pay a person or persons to be an agent or attorney of the Trustees and to authorise them to exercise or perform any or all of the functions of the Trustees except Excluded Functions on such terms and conditions as the Trustees think fit provided that such authorisation is given in writing and such arrangements are kept under review. For the purposes of this clause, Excluded Functions means a function that is, or is related to:

(a) the exercise of a discretion to pay, apply or appropriate or decide to pay, apply or appropriate, the whole or any part of the Trust Fund;

(b) the exercise of a discretion to determine whether any payment from the Trust Fund is a payment from income or capital;

(c) the exercise of a discretion to determine whether any payment received by the Trustees should be appropriated to income or capital;

(d) a right conferred on Trustees to apply to the Court; or

(e) a right to delegate the exercise of the Trustees’ functions.

30 **To enter into contracts and arrangements**
To enter into any type of contract, commitment, arrangement or understanding to assume or reallocate risk, rewards, rights or obligations on such terms as the Trustees think fit.

31 **To vary contracts and arrangements**
To vary, assign, novate, waive, terminate or otherwise deal with on such terms as the Trustees think fit any contract, commitment, arrangement or understanding to which the Trustees are party.

32 **Do all other necessary or desirable things**
The Trustees may do all other lawful things that are necessary or desirable in their opinion for the carrying out of the purposes of the Trust.
SCHEDULE 2: BRASS PLATE

[photo]
EXECUTION

Counties Manukau District Health Board
as Settlor

___________________________
Director

in the presence of:

___________________________
Name:

Occupation:

Address:

Signed by [ ] as Trustee

___________________________
in the presence of:

___________________________
Name:

Occupation:

Address:

Signed by [ ] as Trustee

___________________________
in the presence of:

___________________________
Name:

Occupation:

Address:
RESOLUTIONS OF THE TRUSTEES OF THE ALICE NELSON CHARITABLE TRUST

passed on day of 2017

Introduction
1 

The Trustees have, at today’s date, settled the Alice Nelson Charitable Trust (the Trust) with an initial gift of [$10] and the transfer of a brass plate made to commemorate Alice Nelson.

2 Each of the Trustees appointed under the Trust Deed, being [ ], [ ] and [ ] (the Trustees) accept their respective appointments as Trustees of the Trust.

3 The Trustees wish to acknowledge Mr Edward Nelson, whose generosity has brought this Trust into being.

The Trustees have resolved:
4 That any one of the Trustees is authorised to open a bank account in the name of the Trust on the bank’s usual terms and conditions operated by trusts and authorise the Trustees to operate the account jointly.

5 To apply for registration as a charity under the Charities Act 2005.

6 To apply for an IRD number for the Trust.

7 To apply for incorporation as a charitable trust board under the Charitable Trusts Act 1957.

8 That the Trust is intended to continue until such time as, in the opinions of the Trustees, it becomes impossible, impracticable or inexpedient to carry out the specific purposes of the Trust, or otherwise with the approval of the Court.

9 That they will continue to discuss capital protection and, at their next meeting, agree a policy on capital protection which will then guide them and all subsequent Trustees in their dealing with and protection of capital. This policy may involve reserving a certain percentage of income and adding it to capital and restrictions around the circumstance in which capital can be used.

10 That they will consider what may be appropriate to be in their Statement of Investment Policy.

11 The Trustees will appoint a reputable investment manager to invest such funds as they agree to invest, in alignment with their Statement of Investment Policy.

12 When making decisions on how the Trust Fund is to be distributed, the Trustees acknowledge that the purposes of the Trust are:

12.1 To provide financial and other assistance to Nurses and Midwives who need assistance whether through age, physical or mental ill-health, accident or disability. The Trust Fund can be used, for example, to provide care packages
or fund time in rest and recreation facilities to Nurses and Midwives undergoing long-term medical treatment.

12.2 To provide financial and other assistance to Nurses and Midwives and/or their families in financial need. The Trust Fund can be used, for example, to provide accommodation to or cover transport expenses of family members of a Nurse or Midwife who is undergoing long-term medical treatment away from their usual place of residence.

12.3 For any other similar purposes within New Zealand (whether relating to the relief of poverty, the advancement of education or any other matter beneficial to the community) which are charitable according to the law of New Zealand. For example the Trustees may use their discretion to donate a portion of the Trust Fund to a New Zealand charity with similar purposes to those set out at 10.1 and 10.2 above.

13 The Trustees accept the ongoing obligation to retain records including:

13.1 The Trust Deed;

13.2 Details of all settlements on the Trust, by whom they were made (name and address) and when;

13.3 Details of all distributions from the Trust, the recipients (names and addresses) and the dates;

13.4 All entries of money received and expended by the Trustees in relation to the Trust and what they relate to;

13.5 Details of all assets and liabilities of the Trust; and

13.6 Sufficient accounting records to enable the financial position of the Trust to be ascertained at any time.

(Trust Documents)

14 Such Trust Documents will be retained for at least seven years after the end of the Income Year to which they relate.

15 The Trust Documents will be held at the offices of CMDHB Board Office, Building 2, 19 Lambie Drive, Manukau, Auckland 2104.

16 The Trustees may execute such other documents and do such other things as may be necessary or desirable to establish the Trust and complete the matters referred to above.

Signed by the Trustees of the
Alice Nelson Charitable Trust

[          ]

100194707/5435316.1
Counties Manukau District Health Board
Metro Auckland Urgent Care After Hours Procurement

Recommendation
It is recommended that the Board:

Note that on 28 February 2018 the Board endorsed establishing subsidised access for high needs groups to urgent care services across the district, including after hours (until 8pm) at up to eight clinics and extended hours (8pm until 11pm) at up to four clinics.

Note that negotiations with the preferred providers have now been concluded and 120,000 patient visits per annum will now be subsidised for low income patients at clinics spread across the localities, with a maximum co-payment of $39 for adults in the target group, and free access for all under 13’s until 11pm.

Agree that the public and other interested parties be informed via a media release and other communications of the new arrangements, which represent a doubling of access to subsidised urgent after hours care in Counties Manukau.

Prepared and submitted by Benedict Hefford, Director of Primary, Community and Integrated Care.

Purpose
This briefing provides an update to the Board regarding the outcome of the regional Urgent Care After Hours procurement process.

Background
In 2017, the Auckland, Counties Manukau, and Waitemata DHBs developed and released a joint Request for Proposal (RFP) for ‘after hours’ (5pm to 8pm) and ‘overnight’ (8pm to 8am) urgent care services.

On 28 February 2018, the CMH Board considered the outcome of the regional procurement negotiations and subsequently agreed to endorse finalisation of agreements for ‘after hours’ urgent care services in CMH, and establish an arrangement for ‘extended hours’ urgent care services to mitigate affordability issues identified through the RFP process. It was also agreed that all reasonable attempts to mitigate the budget pressures would be taken, including further price negotiations with providers, approaching PHOs to re-start their funding contributions, and, if necessary, potentially reducing service coverage. The Minister of Health’s office and Ministry of Health have been kept regularly updated of progress.

Progress
Subsequent to Board approval we have concluded negotiations with the preferred providers. As part of these negotiations, the three DHBs kept some key elements in common across the region, including:

- Subsidised population groups targeting equity (High User Health Cards or Community Services Cards, low income residents, and people aged 65 or over);
- $39 maximum co-payment for the subsidised population groups;
- Free after hours care for under 13 year olds;
- Attainment of urgent care accreditation standards, and
• Appropriate data collection to support the on-going performance and quality framework of the Auckland Regional After Hours Network.

There are however some differences across the region. As previously agreed by the Board, we have not proceeded with the overnight component (8pm to 8am) and have instead established an interim solution with four providers (one in each locality) to provide extended hours services from 8pm to 11pm. The extended hours services will remain consistent with the common after hours elements described above. Commencing 1 July 2018, we will have subsidised urgent care services for high needs groups at the following clinics:

<table>
<thead>
<tr>
<th>After Hours Clinics: 5pm till 8pm</th>
<th>Co-payments for children under 13 years</th>
<th>Co-payments for other subsidised patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETHC Mangere</td>
<td>$0</td>
<td>$37.50</td>
</tr>
<tr>
<td>ETHC Dawson Rd</td>
<td>$0</td>
<td>$37.50</td>
</tr>
<tr>
<td>ETHC Browns Rd</td>
<td>$0</td>
<td>$37.50</td>
</tr>
<tr>
<td>ETHC Bairds Rd</td>
<td>$0</td>
<td>$30</td>
</tr>
<tr>
<td>Counties Medical Takanini</td>
<td>$0</td>
<td>$35</td>
</tr>
<tr>
<td>Counties Medical Papakura</td>
<td>$0</td>
<td>$35</td>
</tr>
<tr>
<td>East Care Howick</td>
<td>$0</td>
<td>$39</td>
</tr>
<tr>
<td>Urgent Care Franklin</td>
<td>$0</td>
<td>$39</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extended Hours Clinics: 8pm till 11pm</th>
<th>Co-payments for children under 13 years</th>
<th>Co-payments for other subsidised patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETHC Bairds Road</td>
<td>$0</td>
<td>$30</td>
</tr>
<tr>
<td>Counties Medical Papakura</td>
<td>$0</td>
<td>$39</td>
</tr>
<tr>
<td>East Care Howick</td>
<td>$0</td>
<td>$39</td>
</tr>
<tr>
<td>Urgent Care Franklin</td>
<td>$0</td>
<td>$39</td>
</tr>
</tbody>
</table>

These clinics are in the following locations:
**Funding**

In the paper presented to the Board on 28 February, an estimated cost for both the after-hours and extended hours services was presented. The paper also maintained that whilst the negotiation team would continue to work with providers to reach an agreement that remains within the parameters of the budget, that prices submitted via the RFP were based upon assumptions around hours and attendance volumes, and that changes to these parameters may impact the pricing if there are impacts on economies of scale.

At the conclusion of the negotiations we have agreed a final cost below the maximum estimated level (with a slightly higher than expected estimated volume level also). The following table presents the previous estimates in comparison to final agreed price and estimated volumes.

<table>
<thead>
<tr>
<th></th>
<th>Previous Estimated Price ($000’s)</th>
<th>Previous Estimated Volumes</th>
<th>Final Price ($000’s)</th>
<th>Final Estimated Volumes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>$5,050-$5,700</td>
<td>118,612</td>
<td>$5,324</td>
<td>120,465</td>
</tr>
</tbody>
</table>

It is worth noting that the increased investment by the Board (~ $2 million) has:
- More than doubled the current access, with subsidised visits now available at eight clinics, up from three, and
- The number of patient visits subsidised each year has increased by 140%, from a previous 50,000 subsidised volumes to 120,000.

The main change from current service provision is that Eastcare will only receive funding until 11pm for subsidised visits by high needs patients. However, Eastcare - with support from Easthealth PHO - has decided to continue their overnight service utilising clinicians delivering Hospital in the Home services in the Eastern Locality. Hospital in the Home allows treatment to be delivered within a patient’s own home or community based locations, and supports the transition of care from hospital. An Advanced Paramedic will be based at the Botany Superclinic to provide overnight clinical cover for both Hospital in the Home and urgent care patients. This partnership model allows both Eastcare/Easthealth and CMH to meet our shared objectives of delivering care closer to home, reducing demand on hospital services (by reducing length of stay and supporting admission avoidance), and improving transitions of care. The initiative will also support the development of an innovative new workforce and model of care in collaboration with St. John’s Ambulance Trust.

**Communications**

The new arrangements are now in place and the clinic locations and hours and costs of access will now be communicated via media releases, social media, locality networks and other channels.
Decision Paper
Counties Manukau District Health Board
Proposed Internal Audit Plan 2019-2021

Recommendation
It is recommended that the Board:


Note this paper was endorsed on 6 June 2018 at the Audit Risk & Finance Committee to go forward to Board.

Approve the proposed FY2019 Internal Audit Plan.

Submitted by: Ramon Manzano, General Manager - Regional Internal Audit (RIA)

Purpose
To present the Proposed Internal Audit Plan FY2019 to the Board for approval.

Background
A Draft Internal Audit Plan FY2019 was presented at the last ARFC meeting and comments were obtained and incorporated into this Proposed Internal Audit Plan. Below is high-level description of our Internal Audit Planning process:

<table>
<thead>
<tr>
<th>Report</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed Internal Audit (June 6)</td>
<td>Submit Proposed Internal Audit Plan after considering comments from ARFC and Management on the Draft Internal Audit Plan presented at its April 23 meeting. Present this result in an Approved Internal Audit Plan.</td>
</tr>
<tr>
<td>Approved Internal Audit Plan (July 18)</td>
<td>Submit the Approved Internal Audit Plan with visibility of other DHB plans. Further adjustments can be made after seeing what audits are planned at the other DHBs. Present this result in the Final Audit Plan – aligned with the Region.</td>
</tr>
<tr>
<td>Final Internal Audit Plan (Aug 29)</td>
<td>RIA has a flexible internal audit plan and changes throughout the year can be made in response to new risks or situations.</td>
</tr>
</tbody>
</table>

At the start of the Internal Audit Planning process, RIA submits the Draft Internal Audit Plan for the new financial year (FY2019) and indicative plans for further two years (FY2020 and FY2021). These plans are designed to address the unique set of risks CMDHB is facing and are determined after consulting the following parties:

- Audit New Zealand (Audit NZ) Director
- CMDHB Management

1 The detailed internal Audit Planning process is presented in Appendix 1.
- Risk Manager
- RIA Management
- Audit Managers at other DHBs

and by referring to the following documents:
- CMDHB and hA Risk Registers
- Audit NZ Management Letter
- Previous RIA Reports
- Audit Plans at other Northern Region DHBs
- Institute of Internal Auditors publications

**Features of RIA Audit Plans**
The Proposed Internal Audit plan has the following features:

1. **Strengthening the RIA’s data analytics capability.**
   
   Included in last year’s budget is an additional FTE for our CAATTs\(^2\) Team. We now have 1.75 FTE involved in data analytics. While this Team is small, their use of ACL\(^3\) allows them to audit:
   
   ✓ 100% of Accounts Payable transactions 600,000 invoices per year  
   ✓ 100% of vendor details 17,300 vendor accounts  
   ✓ 100% of employee records 26,500 employees

   Over the years, our CAATTs Team has delivered audit efficiencies made possible by improvements in computing speed and audit software technology.

   CAATTs holds a promising future as it is trending towards ‘predictive analytics’ as illustrated below:

   ![Predictive Analytics Diagram](image)

   In the past, internal auditing mainly reported what happened months ago; but with the advent of more powerful computers and advanced audit software, we gradually started auditing in real-time. This is currently where our CAATTs Team is positioned. Account Payable transactions for instance

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\(^2\) Computer Aided Auditing Tools and Technique. Also known as Data Analytics.  
\(^3\) Audit Command Language – data analytics software tool in use at RIA.
are audited every night and audit issues found are passed on to line managers the following morning.

In recent years, the focus has been in computerising processes and this resulted in an accumulation of big data. If the technological trend continues, advanced auditing software is expected to utilise all this data to make predictions of likely issues; thus allowing organisation to be more proactive.

2. **Reviewing Sensitive Expenditure** and CME.

   To preserve the DHB’s reputation, and protect staff’s reputation, RIA is allocating resources to reviewing Sensitive Expenditure. This involves evaluating the approval process and examining transactions to establish validity and probity. Our indicative audit plans involve extending this review to FY2020 and FY2021. However, the extent of these reviews depends on results of the FY2019 review.

3. **CyberSecurity**

   This is the third year RIA is auditing this area. Our first audit had 50 recommendations that have been implemented over two years. The focus of this year’s audit is to update our audit findings to account for any new risks that have arisen.

4. **Procurement**

   A Regional Procurement Policy was issued April 2018. One of the requirements is for the procurement team to appoint an independent probity advisor for procurements of significant value or complexity. Given our experience in performing probity audits on selective projects, RIA could be called upon to provide this service.

5. **Non-Financial Reporting**

   For the past two years, RIA has been assisting Audit New Zealand obtain assurance on the accuracy of national health target reports by the DHBs. In FY2017, all four DHBs had their 'qualified audit opinion' removed in their annual reports. RIA will continue to allocate resources in this area.

6. **Control Self-Assessment (CSA)**

   To achieve a wider audit coverage with the same level of funding, RIA is continuing to roll out its CSA program. For medium to low risk areas, RIA has been introducing a system of self audits allowing line managers to monitor the effectiveness of their internal controls. RIA’s role is to check a sample of these self-audits to validate that agreed procedures have been followed and conclusions properly supported. Time savings afforded by CSA allows RIA to focus on the higher risk areas.

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4 Type of DHB expenses that could also be viewed as giving personal benefits. Examples are: business travel, meals & accommodation, entertainment, fuel cards, company credit cards, etc.

5 First Audit Report, dated 1 April 2016
7. Research & Development

RIA will be creating a new service calling it R&D. The purpose is to issue quarterly updates on trends in internal auditing and their implications for the DHB. We are allocating 28 audit days to research and report throughout the year on the following trends:

- Blockchain Technology
- Predictive Analytics
- Cloud Services
- Agile Auditing

The purpose of these activities is to become aware of relevant trends and to monitor their progress and relevance to RIA or DHB operations. Such trends could also be the source of emerging risks or opportunities that the DHB should prepare for.

Proposed Internal Audit Plan

We prepared this Proposed Internal Audit plan with no increase in the current internal audit budget. Consequently, only high priority audits are scheduled in FY2019 while those with lower priorities are scheduled for FY2020 and FY2021.

It is the Committee’s responsibility to advise RIA if any of the audits earmarked for FY2020 and FY2021 should be prioritised and scheduled for FY2019 or if there are additional areas it requires RIA to cover. These may result in an increase in budget but if a corresponding number of audits in FY2019 is de-prioritised to FY2020 or FY2021, the audit budget could remain the same.

<table>
<thead>
<tr>
<th>Audit Name</th>
<th>assurance provided$^a$</th>
<th>R or L</th>
<th>Risk</th>
<th>FY2019 (days)</th>
<th>FY2020 (days)</th>
<th>FY2021 (days)</th>
<th>CMDHB Risk ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Procurement Probity per Regional Procurement Policy</td>
<td></td>
<td>L</td>
<td>H</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>2. CCM$^b$ Accounts Payable &amp; Duplicate Payments</td>
<td>No duplicate invoices are paid and recoveries are made for those that are.</td>
<td>R</td>
<td>H</td>
<td>28</td>
<td>28</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>3. Sensitive Expenditures</td>
<td>Employee expenses are reasonable and business related.</td>
<td>L</td>
<td>H</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>4. CyberSecurity</td>
<td>IT systems are protected against cyber-attacks.</td>
<td>R</td>
<td>H</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>2.15</td>
</tr>
<tr>
<td>5. Overseas Travel (bi-annual)</td>
<td>Travel expenses have been authorised and are valid.</td>
<td>L</td>
<td>M</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>6. CCM$^c$ Payroll</td>
<td>The correct salaries and reimbursements are paid to bonafide staff.</td>
<td>R</td>
<td>M</td>
<td>27</td>
<td>27</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>7. Vendor Management &amp; Monitoring</td>
<td>Vendor accounts are valid and changes to their bank accounts are authorised.</td>
<td>R</td>
<td>H</td>
<td>20</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Advisory on ReNOS$^d$</td>
<td>The Northern Region DHBs' systems are setup for the National Oracle System.</td>
<td>R</td>
<td>H</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Non-Financial Reporting</td>
<td>Audit NZ is satisfied with the accuracy of the DHB's non-financial reports.</td>
<td>L</td>
<td>M</td>
<td>25</td>
<td>25</td>
<td></td>
<td>2.4,</td>
</tr>
<tr>
<td>10. Recruitment: Pre-employment screening, COI</td>
<td></td>
<td>L</td>
<td>H</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$^a$ Once draft audit list is accepted RIA will define their audit scope
$^b$ Regional audit or Local audit
$^c$ Continuous Controls Monitoring.
$^d$ Regional National Oracle Solution
<table>
<thead>
<tr>
<th>Audit Name</th>
<th>assurance provided</th>
<th>R or L</th>
<th>Risk</th>
<th>FY2019 (days)</th>
<th>FY2020 (days)</th>
<th>FY2021 (days)</th>
<th>CMDHB Risk ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a robust background checking in the recruitment process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13.1</td>
</tr>
<tr>
<td>11. Project Management (PIRs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projects are managed to deliver expected benefits on time and within budget.</td>
<td>L</td>
<td>H</td>
<td>30</td>
<td></td>
<td></td>
<td>18.1</td>
<td></td>
</tr>
<tr>
<td>12. Cash Flow</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash flow forecasts are accurate.</td>
<td>L</td>
<td>H</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Bullying &amp; Harassment</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensuring there is zero tolerance for bullying &amp; harassment and there are strong support mechanisms for victims.</td>
<td>L</td>
<td>H</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Holidays Act</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payroll Department is correctly calculating holiday rates.</td>
<td>L</td>
<td>H</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Remediation Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The ‘Remediation Program’ has proper governance in place increasing likelihood of achieving target benefits.</td>
<td>L</td>
<td>H</td>
<td>20</td>
<td></td>
<td></td>
<td>13.19</td>
<td></td>
</tr>
<tr>
<td>16. Health &amp; Safety - harm to staff by patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees feel safe from harm while tending to difficult patients.</td>
<td>L</td>
<td>H</td>
<td>20</td>
<td></td>
<td></td>
<td>2.18, 4.8</td>
<td></td>
</tr>
<tr>
<td>17. Format of Finance Reports to AC &amp; Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ARFC and Board have good visibility through various Finance Reports.</td>
<td>L</td>
<td>H</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Advisory on CSA Payroll</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Payroll Team regularly performs self-audits on their internal control effectiveness.</td>
<td>R</td>
<td>H</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. IT Governance Follow-up post ISSP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All agreed recommendations from IT Governance Report are reflected in the ISSP and LTIP.</td>
<td>R</td>
<td>H</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Advisory on CSA Payables</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Payables Team regularly performs self-audits on their internal controls effectiveness.</td>
<td>R</td>
<td>H</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Data Security</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical and logical access to patient and business data are effectively secured.</td>
<td>R</td>
<td>H</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. IT Asset Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate systems in place to manage regional IT assets (acquisition, maintenance, retirement).</td>
<td>R</td>
<td>H</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Validation of key ‘Turnaround’ Projects and benefit as planned and regional opportunities maximised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assurance that various turnaround projects will deliver benefits to breakeven in future.</td>
<td>L</td>
<td>M</td>
<td>35</td>
<td></td>
<td></td>
<td>5.7, 2.6</td>
<td></td>
</tr>
<tr>
<td>24. Capital Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capex proposals presented to the Audit Risk and Finance Committee are well thought out, follow the required format and appropriately approved.</td>
<td>L</td>
<td>M</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Identity and Access Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network and applications access are appropriate for active employees and contractors.</td>
<td>R</td>
<td>M</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Data Management and Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data integrity is maintained, is managed efficiently, and is used for valid</td>
<td>R</td>
<td>M</td>
<td>9</td>
<td></td>
<td></td>
<td>2.1</td>
<td></td>
</tr>
</tbody>
</table>

---

10 Post Implementation Reviews  
11 Control Self-Assessment  
12 Information Systems Strategic Plan  
13 Long Term Investment Plan  
14 Capital Expenditure
<table>
<thead>
<tr>
<th>Audit Name</th>
<th>assurance provided</th>
<th>CMDHB Risk ID</th>
<th>R or L</th>
<th>Risk</th>
<th>FY2019 (days)</th>
<th>FY2020 (days)</th>
<th>FY2021 (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. R&amp;D: Blockchain Technology</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Quarterly briefing of technology trends in computer technology.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. R&amp;D: Predictive Analytics</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Quarterly briefing of technology trends in data analytics.</td>
<td></td>
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</tr>
<tr>
<td>29. R&amp;D: Agile Auditing</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Quarterly briefing of latest developments in auditing.</td>
<td></td>
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</tr>
<tr>
<td>30. R&amp;D: Cloud Services</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Quarterly briefing of latest developments in cloud technology.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>31. Contracts Management</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>25</td>
<td>25</td>
<td>4.4, 4.5</td>
</tr>
<tr>
<td>Invoices are linked to valid expense contracts and follow contract terms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Health &amp; Safety Deep Dive</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>20</td>
<td>20</td>
<td>4.4, 4.5</td>
</tr>
<tr>
<td>Area to be determined.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. BCP and DRP</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>45</td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>There is an Organisation-wide plan in place to deal with a crisis and has been tested for effectiveness.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Controlled Drugs</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>40</td>
<td></td>
<td>11.1</td>
</tr>
<tr>
<td>Access to controlled drugs is strictly enforced. Controlled Drugs are accounted for.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Policy Compliance - Repairs &amp; Maintenance</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>35</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>Adequate budget for R&amp;M and spending is 'value-for-money' and follows policies.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>36. Anti-Fraud Maturity Assessment</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>30</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Policies, procedures and cultures are in place to prevent or minimise fraud.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Internal Control Environment Assessment</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>30</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>There are good internal controls with a culture of compliance.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>38. Policy Compliance – DFA</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>25</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Staff approve documents within their delegations.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>39. Data Privacy Maturity Assessment</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>30</td>
<td></td>
<td>2.5</td>
</tr>
<tr>
<td>There is a robust system in place to ensure privacy of sensitive data.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Cloud Governance</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>8</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Region has a policy to govern data and applications in the 'cloud'.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. Contractor Management</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>22</td>
<td></td>
<td>6.6</td>
</tr>
<tr>
<td>Spending on contractors is valid; their output measured and offers good value.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. Emergency Department Measures</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>45</td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>Emergency Department (ED) has the correct set of KPIs.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>43. Health &amp; Safety Maturity Assessment</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>35</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>Employees are health &amp; safety conscious and aim to prevent harm and injury to patient and co-workers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44. Succession Planning &amp; Backup</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>30</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Replacements have been identified for key personnel.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. GL Coding: Capex and Opex</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>35</td>
<td></td>
<td>35</td>
</tr>
</tbody>
</table>

---

15 Business Continuity Plan  
16 Disaster Recovery Plan  
17 Delegated Financial Authority  
18 Key Performance Indicators  
19 Operating expenditure
Transactions are recorded accurately as capital or expense.

46. Policy Compliance - Assets Management
There is an asset management plan and it meets policy requirements.

47. RCA\textsuperscript{20}: Unrecorded leave
Determine the root cause of unrecorded leave for purposes of minimising it.

48. CME\textsuperscript{21} of Part-Time SMOs
Full amount of CME is not given to a part-time Senior Medical Officer (SMO) unless the DHB is his or her sole employer.

The above internal audit plan is risk-based and flexible. As new risks emerge, fraud incidents arise, or the risk appetite of the Board changes, this internal audit plan will be adjusted to maintain its relevance.

**Next Step**
At the next ARFC meeting, RIA will present the Regional Internal Audit Plan composed of approved internal audit plans of the four DHBs\textsuperscript{22} and hA. This will give a regional view of our audit activities and provide another opportunity for ARFC members to adjust CMDHB’s Internal Audit Plan.

\textsuperscript{20} Root Cause Analysis
\textsuperscript{21} Continuing Medical Education
\textsuperscript{22} Auckland, Waitemata, Counties Manukau and Northland DHBs.
Appendix 1
The following steps were performed in drafting these Audit Plans:

3.1. Risk Identification
This Audit Plan is risk-based. The first step was to identify key risks that the DHB is facing. To identify these risks, RIA reviewed the Risk Register, External Audit Reports and consulted with Senior Management. RIA’s activities are directed at evaluating how well the DHB identifies and manages its risks.

3.2. Risk Evaluation
Key risks are rated as High, Medium or Low, depending on their perceived likelihood of occurrence and their impact on DHB’s ability to achieve its objectives. Where available, RIA would use the risk ratings assigned in the Risk Register.

3.3. Risk Prioritisation
RIA would then select those major risks where the mitigation strategy identified was to maintain or introduce internal controls. These selected risk areas were then prioritised using the ratings referred to in Step 3.2.

3.4. Resource Planning
The proposed Audit Plan covers three years. To prepare this Audit Plan, the following estimates were used:

3.4a Available Audit Days
These are the days available for RIA to perform the audits. The available audit days exclude non-working-days, leave entitlements, training and team meetings. The Regional Manager’s time is also excluded from the calculation since his time is spent overseeing the internal audit function.

3.4b Audit Days Allocated to DHBs
The audit days allocated to CMDHB is 538 days, as per calculation below. To implement the proposed audit plan, the difference in days is covered by Contractors costs.

<table>
<thead>
<tr>
<th>FY 2019</th>
<th>CMDHB</th>
<th>WDHB</th>
<th>ADHB</th>
<th>NDHB</th>
<th>hA &amp; FPSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>RIA Funding</td>
<td>24.5%</td>
<td>24.5%</td>
<td>39.5%</td>
<td>5.8%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Total Requirement</td>
<td>560</td>
<td>551</td>
<td>853</td>
<td>106</td>
<td>101</td>
</tr>
<tr>
<td>Available - RIA Staff</td>
<td>433</td>
<td>433</td>
<td>698</td>
<td>102</td>
<td>101</td>
</tr>
<tr>
<td>Available - Contractors</td>
<td>105</td>
<td>105</td>
<td>151</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Available</td>
<td><strong>538</strong></td>
<td><strong>538</strong></td>
<td><strong>849</strong></td>
<td><strong>102</strong></td>
<td><strong>101</strong></td>
</tr>
</tbody>
</table>

3.5. Audit Project Selection
A matching of audit resources available (Step 3.4) with the risk prioritisation (Step 3.3), resulted in the proposed audit plan for the next three years.
Decision Paper
Counties Manukau District Health Board
Regional Internal Audit Budget for the 12 Months Ending 30 June 2019

Recommendation

It is recommended that the Board:

Receive the proposed RIA Internal Audit Budget for the 12 months ending 30 June 2019.

Note this report was endorsed on the 6 June 2018 by the Audit Risk & Finance Committee to proceed to Board.

Approve RIA’s request to be allocated the same budget as prior year of $489,744 to deliver its Internal Audit Plan.

Prepared by Ramon Manzano, General Manager – Regional Internal Audit on 28 May 2018

Purpose

To present our Regional Internal Audit’s (RIA) Proposed Budget for FY2019 to the Audit Risk and Finance Committee and receive endorsement for Board approval.

Background

RIA is proposing the same level of funding as last year or $489,744. This represents 0.03% of your FY2017 revenue, which aligns well with other similar size DHBs (see below).

<table>
<thead>
<tr>
<th>DHBs</th>
<th>Internal Audit Budget as % to Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>0.03%</td>
</tr>
<tr>
<td>Waitemata</td>
<td>0.03%</td>
</tr>
<tr>
<td>Northland(^2)</td>
<td>0.02%</td>
</tr>
<tr>
<td>Midland Region(^3)</td>
<td>0.03%</td>
</tr>
<tr>
<td>Central Region(^4)</td>
<td>0.02%</td>
</tr>
</tbody>
</table>

Proposed Budget for FY2019

The details of RIA’s proposed budget are presented in the following page.

---

\(^1\) FY2017 Financial statements are available for the similar size DHBs.
\(^2\) Northland DHB’s only available Financial Statements are for the year ending 30 June 2016.
\(^3\) Comprising Waikato, Taranaki, Tairawhiti, Lakes DHBs
\(^4\) Comprising Capital & Coast, MidCentral, Hawkes Bay, Whanganui, Hutt Valley and Wairarapa DHBs
## Total Proposed Operating Budget

### Expenditure Category

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>For the 12 months ended/ending 30 June ($000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2018</td>
</tr>
<tr>
<td>Salaries &amp; Other Personnel Costs</td>
<td>1,459</td>
</tr>
<tr>
<td>Accommodation*, Parking, Mileage &amp; Work-related travel costs</td>
<td>63</td>
</tr>
<tr>
<td>Professional Subscriptions, Staff Development &amp; Reference Materials</td>
<td>37</td>
</tr>
<tr>
<td>Telecommunications, Computer Leases, Software &amp; Low Value Hardware</td>
<td>45</td>
</tr>
<tr>
<td>Contractors &amp; Other External Advisors</td>
<td>392</td>
</tr>
<tr>
<td>Stationery, Postage, Couriers &amp; Other Incidentals</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total Budget</strong></td>
<td><strong>1,999</strong></td>
</tr>
<tr>
<td><strong>CMDHB Contribution</strong></td>
<td><strong>490</strong></td>
</tr>
<tr>
<td><strong>Funding Share of Total</strong></td>
<td><strong>24.5%</strong></td>
</tr>
</tbody>
</table>

---

5 For Northland DHB Audits.
**Recommendation**

It is recommended that the Board:

**Receive** this paper which documents the rationale for increased bed capacity for General Medicine over the winter period.

**Note** that if the recommendation in this paper is approved the additional bed capacity will be located in Ward 21.

**Approve** the establishment of 30 beds on Ward 21 for use by General Medicine in winter.

**Note** the cost of the additional 30 beds for winter is estimated to be $2.3 million. We expect this cost will be partially offset by savings of $1.4 million generated through the General Medicine Change Programme and the closure of beds across General Medicine during the remainder of the year. These savings are in addition to those identified in the Turn Around Plan.

**Note** The net incremental cost of establishing Ward 21 for use in winter is $0.9 million.

**Prepared and submitted by** Brad Healey, General Manager, Emergency Department, Medicine & Integrated Care and Carl Eagleton, Clinical Director Medicine & Integrated Care on behalf of Phillip Balmer, Director Hospital Services and Vanessa Thornton, Acting Chief Medical Officer

**Purpose**

The purpose of this paper is to seek Board approval to open an additional 30 beds for the four month period July to October 2018 at a cost of $2.3 million, to address the increase in patient volumes expected to present to General Medicine during the coming winter period. At the end of this period, we will reduce down resourced bed capacity (by 29 beds) that will save $1.4 million of the incremental winter costs, leaving $0.9 million net incremental cost.

**Background**

Over the past two years inpatient bed capacity particularly during the winter period has been a major challenge for Middlemore Hospital and particularly the General Medicine Service. During the winter of 2017, despite our best efforts to plan an appropriate level of bed capacity we struggled to cope with the increased winter demand further compounded by increasing patient complexity, an aging demographic and high levels of socioeconomic deprivation. Medicine bed occupancy ran above 100% for six months of the year. This has resulted in delays to patient care, patients being cared for in less than optimal environments (eg gastroenterology procedure room), increased clinical risk and the inherent inefficiencies created because of the need to spread patients across multiple locations outside of the General Medicine ward environment.

These pressures have impacted patient flow in General Medicine over the past two years and resulted in an increase in Average Length of Stay (ALOS) from 3 days up to 3.4 days. This equates to a significant increase in the number of acute bed days used, hence the pressure on patient flow and increased bed occupancy (up to 130%). The main increase has been amongst those patients staying greater than 11 days. This group now account for 7.2% of admissions but 1/3 of General Medicine bed days.

As part of the winter planning process we have identified a need to increase General Medicine bed
capacity to cope with the expected increase in presentations during the winter period. For the past two years, General Medicine has been working on a significant change programme which is intended to improve patient flow, the quality of care and the general working environment for our staff. However, these initiatives will not of themselves solve the bed capacity issues for winter 2018.

**Context of the Challenges for General Medicine**

*Our population*

Based on MoH data, CM Health has a high level of deprivation within its population as evidenced below:

<table>
<thead>
<tr>
<th>Population health</th>
<th>Deprivation Quintile Comparison – Standardised Acute Bed Days per Capita Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Pop</td>
</tr>
<tr>
<td>Counties</td>
<td>547,190</td>
</tr>
<tr>
<td>Waitemata</td>
<td>603,960</td>
</tr>
<tr>
<td>Auckland</td>
<td>515,810</td>
</tr>
<tr>
<td>Canterbury</td>
<td>548,840</td>
</tr>
<tr>
<td>Waikato</td>
<td>403,510</td>
</tr>
</tbody>
</table>

CM Health population continues to grow with high and particularly complex healthcare needs due to socioeconomic deprivation, cultural diversity, obesity and aging population.

**Does high level of deprivation impact CMH performance?**
Standardised Acute Bed Days used per Capita based on Deprivation Quintiles is as follows:

**Deprivation Quintile Comparison – Standardised Acute Bed Days per Capita Rates**

**Counties Manukau DHB of Domicile**

<table>
<thead>
<tr>
<th>Dep Quintile</th>
<th>Estimated Popn</th>
<th>Acute Stays</th>
<th>Acute Bed Days</th>
<th>Standardised Acute Bed Days per 1,000 Popn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year to Dec 2017</td>
<td>Year to Dec 2017</td>
<td>Year to Dec 2017</td>
<td>Year to Dec 2017</td>
</tr>
<tr>
<td>1</td>
<td>97,494</td>
<td>6,522</td>
<td>241</td>
<td>251</td>
</tr>
<tr>
<td>2</td>
<td>91,759</td>
<td>6,613</td>
<td>251</td>
<td>255</td>
</tr>
<tr>
<td>3</td>
<td>76,669</td>
<td>5,819</td>
<td>225</td>
<td>234</td>
</tr>
<tr>
<td>4</td>
<td>84,904</td>
<td>6,554</td>
<td>233</td>
<td>245</td>
</tr>
<tr>
<td>5</td>
<td>106,191</td>
<td>36,112</td>
<td>119,111</td>
<td>820</td>
</tr>
<tr>
<td>Total</td>
<td>547,190</td>
<td>65,524</td>
<td>226,698</td>
<td>463</td>
</tr>
</tbody>
</table>

**National**

<table>
<thead>
<tr>
<th>Dep Quintile</th>
<th>Estimated Popn</th>
<th>Acute Stays</th>
<th>Acute Bed Days</th>
<th>Standardised Acute Bed Days per 1,000 Popn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year to Dec 2017</td>
<td>Year to Dec 2017</td>
<td>Year to Dec 2017</td>
<td>Year to Dec 2017</td>
</tr>
<tr>
<td>1</td>
<td>977,995</td>
<td>85,207</td>
<td>267,643</td>
<td>287</td>
</tr>
<tr>
<td>2</td>
<td>957,581</td>
<td>94,220</td>
<td>309,202</td>
<td>338</td>
</tr>
<tr>
<td>3</td>
<td>940,367</td>
<td>105,029</td>
<td>368,612</td>
<td>377</td>
</tr>
<tr>
<td>4</td>
<td>931,547</td>
<td>134,411</td>
<td>452,457</td>
<td>481</td>
</tr>
<tr>
<td>5</td>
<td>941,970</td>
<td>166,595</td>
<td>534,798</td>
<td>654</td>
</tr>
<tr>
<td>Total</td>
<td>4,749,460</td>
<td>589,942</td>
<td>1,932,713</td>
<td>434</td>
</tr>
</tbody>
</table>

**CMH has 20% of the National Quintile 5 population & 22% acute bed days.**

It should be noted that whilst CMH has 20% of the National Quintile Population, this population represents only 12% of the national population in general.

We believe that this high level of deprivation has a flow on impact into the nature and complexity of presentations which has a disproportionate impact on ALOS for CM Health, particularly in General Medicine.

A comparison of Total Actual Acute Bed Days per Capita (see below) shows that CMH has reduced bed days per capita over the past three years albeit at a slower rate of decrease than other large DHBs.

**Actual Acute Bed Days per Capita (MoH data)**

<table>
<thead>
<tr>
<th></th>
<th>Estimated Pop</th>
<th>Actual Acute Bed Days per 1000 Pop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year to Dec 2017</td>
<td>Year to Dec 2015</td>
</tr>
<tr>
<td>Auckland</td>
<td>515,810</td>
<td>434.9</td>
</tr>
<tr>
<td>Canterbury</td>
<td>548,840</td>
<td>415.9</td>
</tr>
<tr>
<td>Capital &amp; Coast</td>
<td>309,050</td>
<td>354.4</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>547,190</td>
<td>425.9</td>
</tr>
<tr>
<td>Waikato</td>
<td>403,510</td>
<td>495.2</td>
</tr>
<tr>
<td>Waitemata</td>
<td>603,960</td>
<td>477.4</td>
</tr>
</tbody>
</table>
Patient Flow

Some key measures that reflect patient flow through the hospital and the challenge we have for General Medicine are as follows:

<table>
<thead>
<tr>
<th></th>
<th>CMH ALOS</th>
<th>Average HRT ALOS</th>
<th>CMH Relative Stay Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>3.5</td>
<td>3.1</td>
<td>102%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>4.3</td>
<td>4.7</td>
<td>99%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>4.3</td>
<td>2.9</td>
<td>124%</td>
</tr>
<tr>
<td>Renal Medicine</td>
<td>4.0</td>
<td>4.2</td>
<td>97%</td>
</tr>
</tbody>
</table>

The above analysis highlights the following:

1. The need to create bed capacity to improve patient flow and the quality of care (including reducing mortality rates). Studies have shown there is a link between mortality rates and bed occupancy – the higher the bed occupancy the greater the mortality rate.
2. The need to focus on the impact that long stay patients have on bed occupancy. This patient group has grown by 2.6% since 2015 but the result is that they occupy 7,345 bed days more equating to 20 beds. The ALOS for the long stay patient group is 15.4 days. If we could reduce this group of 1,332 patients in 2018 from 15.4 days to 10 days then we could potentially save the equivalent of 1 ward of beds.
3. A need to focus on General Medicine and Cardiology ALOS but noting that we perform well in both Respiratory and Renal Medicine.

In addition, we need to be mindful of the impact poor patient flow has on our staff. We have received feedback from both medical and nursing staff indicating exceptional levels of stress and concern about their capacity to maintain standards of care based on the challenges of last winter. It is critical we ensure we have adequate capacity (staff and beds) to minimise the negative impact of poor patient flow.

Winter Plan and Forecast Bed Needs

CM Health uses the CapPlan tool to forecast bed occupancy. The tool is based on historical patterns, forecast volumes for the period ahead and reflects service or process changes as advised by Services. The tool calculates forecast occupancy based on a daily average after taking account of
a “buffer factor” to account for daily peaks in occupancy, flexibility in capacity to incorporate bed turn, isolation requirements and management of gender limitations. In prior years, General Medicine has increased bed capacity during winter by the transfer of 10 or 20 beds from Surgery, over census beds on medical wards and use of the gastroenterology procedure bed waiting area.

The winter forecast for General Medicine is set out below:

**General Medical Beds Forecast (incl + 20 from Surgery)**

[Diagram showing bed forecast over winter]

Transfer of 20 beds from Surgery not sufficient for winter

**General Medical Beds Forecast (incl + 20 from surgery & + 30 Ward 21)**

[Diagram showing bed forecast over winter]

Additional beds as above will meet forecast bed demand for winter

The following should be noted:

1. With the transfer of 20 beds from Surgery the forecast maximum bed deficit in any one day for General Medicine over winter is 54 beds (occurs in July 2018).
2. With the addition of 30 beds (Ward 21) in addition to the 20 beds from Surgery, the forecast maximum bed deficit in any one day for General Medicine over winter is 24
The Change Programme for General Medicine

At the same time as planning for winter demand, we are also undertaking an ambitious change programme. One of the objectives is to free up bed capacity through reducing ALOS. The change programme includes:

1. Introduction of Home Based Wards – we have already implemented this from a nursing structure perspective. The next step is to introduce this for medical staff. The change to ward based teams will improve efficiencies by:
   - Enhanced Multi-disciplinary involvement (MDT) in patient care at an earlier stage.
   - Improve timely delivery of care by medical teams.
   - Improved efficiency with ward rounds focused on 1-2 wards (reduce ‘safari’ rounds).
   - Improved patient & family/whanau experience by predictable ward round times and improved engagement.

2. Introduction of a new medical staffing roster – this is a necessary part of introducing home based wards. To date we have been hampered in implementing this due to the lack of bed capacity to make home based wards work and the flow on impact of the schedule 10 MECA requirements for junior medical staff. We are currently in the consultation phase with staff and unions which runs until 30 June 2018.

3. Structured Interdisciplinary Based Rounds (”SIBR”) – following introduction of home based wards, we plan to introduce a significantly improved ward rounding process which we believe will create significant efficiencies in patient flow and should lead to a reduced ALOS.

4. Long Stay Patients – have a major impact on bed capacity availability. Common themes include waiting for external funding agencies, waiting for placement and medically unwell patients. Accordingly, we are focused on improving our processes to manage this group of patients with the aim of reducing ALOS through enhancing the relationship with Community Central to ensure Long Stay risk is identified early and appropriate discharge planning & placement needs are actioned in parallel with medical care.

5. Zero day patients – we are currently working to discharge those patients that go home within 24 hours even earlier.

6. Enhanced model of Hospital in the Home which facilitates moving appropriate patients out of the hospital earlier to their home but still provides hospital level medical oversight in the community, using resources already in place in the community and better utilisation of community services e.g. POAC.

7. Use of Community based beds for patients that are waiting placement.

8. Reduced readmissions by improving consistency of community care for some of the most common presentations to hospital – COPD, CHF, Cellulitis and TIA.

9. Acute Flow Diagnostic – we have engaged Francis Health to assist us in undertaking a diagnostic assessment of acute flow within Middlemore Hospital. We anticipate that this will help further inform us on our acute bed capacity needs and will identify potential opportunities for improvement in patient flow and bed allocation across services. We expect initial outputs from this work will not be available until the week of 18 June. A copy of the Francis Health proposal is attached at Appendix 1.
10. Improving utilisation of the Infusion Centre – this has already been successful in freeing up a small amount of bed capacity on the general medical and sub-specialty wards.

Options to Manage General Medicine Patient Flow in 2018/19

Recognising the requirement that the investment in additional winter bed capacity needs to be cost neutral we have identified an option, the key features of which are:

- Open additional 30 beds on Ward 21 for winter only.
- Close 29 beds over summer months.
- MAU and SAU remain resourced to full capacity.
- Home based wards over 4 wards (as opposed to the planned 5 wards).
- Even with a large number of bed closures in the summer period, we will not be able to totally recover the costs of opening Ward 21 during winter.

A summary of bed capacity for winter and summer for this option is set out below:

<table>
<thead>
<tr>
<th></th>
<th>Winter 1 July - 30 October</th>
<th>Summer 1 Nov - 30 June</th>
<th>Cost $ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Ward 21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resourced beds</td>
<td>30</td>
<td>TBC</td>
<td>2.0</td>
</tr>
<tr>
<td>Medical staffing</td>
<td>interim model</td>
<td>Home based wards</td>
<td>0.3</td>
</tr>
<tr>
<td>Ward Beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Medicine</td>
<td>120</td>
<td>100</td>
<td>(1.4)</td>
</tr>
<tr>
<td>Ward 2 outliers</td>
<td>9</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Ward 34E Surgical</td>
<td>20</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Medicine Sub-Speciality</td>
<td>88</td>
<td>88</td>
<td>TBC</td>
</tr>
<tr>
<td></td>
<td>237</td>
<td>188</td>
<td>0.9</td>
</tr>
<tr>
<td>Short Stay Beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAU</td>
<td>42</td>
<td>42</td>
<td>TBC</td>
</tr>
<tr>
<td>SAU</td>
<td>15</td>
<td>15</td>
<td>TBC</td>
</tr>
<tr>
<td></td>
<td>57</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Total Beds</td>
<td>324</td>
<td>245</td>
<td>0.9</td>
</tr>
</tbody>
</table>

This leaves a net incremental cost of $0.9 million.

Whilst we have in the past opened and closed additional bed capacity for winter, it should be noted that we have not done it on the scale proposed in this paper.
The bed closures at the end of winter will be undertaken in a phased way during November 2018. A summary of the required staffing reductions and resultant cost reductions is as follows:

<table>
<thead>
<tr>
<th>Ward 21 Bed Closure (costs incurred from 1/7 - 2/11/18)</th>
<th>FTE</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Nurses</td>
<td>1.2</td>
<td>43</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>25.2</td>
<td>703</td>
</tr>
<tr>
<td>Healthcare Assistants</td>
<td>7.5</td>
<td>131</td>
</tr>
<tr>
<td>Admin &amp; Clerical</td>
<td>1.9</td>
<td>37</td>
</tr>
<tr>
<td>Support Services (incl Allied Health)</td>
<td>17.4</td>
<td>432</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>4.8</td>
<td>261</td>
</tr>
<tr>
<td>Total</td>
<td>58.0</td>
<td>1,607</td>
</tr>
</tbody>
</table>

| Non Staffing Costs                                     |     | 427  |
| Total                                                  | 58.0| 2,034|

<table>
<thead>
<tr>
<th>Bed Closures Across Other Wards (costs saved from 30/11/18 - 30/6/19)</th>
<th>FTE</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses</td>
<td>20.0</td>
<td>1,040</td>
</tr>
<tr>
<td>Healthcare Assistants</td>
<td>1.4</td>
<td>50</td>
</tr>
<tr>
<td>Supplies</td>
<td></td>
<td>340</td>
</tr>
<tr>
<td>Total</td>
<td>21.4</td>
<td>1,430</td>
</tr>
</tbody>
</table>

The Ward 21 nursing staff have been employed and are currently deployed across medical wards whilst they undertake orientation processes. The majority of those staff have been employed on permanent contracts. Our plan is to close Ward 21 with staff being redeployed to reduce establishment FTE by 2 November. Bed closures across other wards will be undertaken in a phased way during November. Our plan is to transfer the staff to any vacant positions and to backfill other staff enabling them to reduce high annual leave balances. Over the next month we will develop a detailed redeployment and annual leave plan in conjunction with senior leadership and the recruitment team.

We have considered another option which would have Ward 21 opened on a permanent basis but are cognisant of the fact that we are not confident we could reduce cost over the summer period to offset the incremental cost incurred.

The output from the Francis Health acute flow diagnostic should identify additional opportunities for efficiencies, to enable further reduction to resourced beds and/or the creation of additional bed capacity within the current system to absorb future growth.
Metrics to monitor patient flow

We have developed the following metrics to monitor performance against the plan:

<table>
<thead>
<tr>
<th>Emergency Department &amp; Medicine</th>
<th>Target</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients admitted, discharged, transferred from ED within 6 hrs</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>Medical Assessment – Triage 3-5 patients seen within 60 minutes</td>
<td>60</td>
<td>95</td>
</tr>
<tr>
<td>% of patients &lt; 28 hrs discharged from inpatient wards</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>% Discharged from Medical Assessment Unit by 1100hrs</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>% Discharges from transit lounge or home by 1100hrs</td>
<td>30%</td>
<td>16%</td>
</tr>
<tr>
<td>Day Zero Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay Acute</td>
<td>3.2</td>
<td>3.4</td>
</tr>
<tr>
<td>Gen Med LOS &gt; 10 days (number of patients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Readmissions within 28 days - Total</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>Acute Readmissions within 28 days - 75+</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>% of patients on home wards in General Medicine</td>
<td>75%</td>
<td>37%</td>
</tr>
<tr>
<td>% of Outliers on non-medicine wards</td>
<td>0%</td>
<td>12%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Target</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of stay - Acute Inpatient incl Burns</td>
<td>3.8</td>
<td>3.82</td>
</tr>
<tr>
<td>Average Length of Stay - Acute Inpatient excl: Burns</td>
<td>3.8</td>
<td>3.79</td>
</tr>
<tr>
<td>Average Length of Stay - Acute Inpatient excl: Burns and Spina Ortho</td>
<td>3.5</td>
<td>3.78</td>
</tr>
<tr>
<td>Recovery 23 hour LOS. All patients d/c within 23 hours</td>
<td>99%</td>
<td>NA</td>
</tr>
<tr>
<td>MMH % patients discharged to discharge lounge or home by 1100hrs</td>
<td>30%</td>
<td>26%</td>
</tr>
<tr>
<td>Average Length of Stay - SAU</td>
<td>340 mins</td>
<td>350 mins</td>
</tr>
<tr>
<td>Pre-operative length of Stay days (from admit to surgery)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>% of patients d/c from SAU</td>
<td>0.3</td>
<td>21%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARHOP</th>
<th>Target</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average AT&amp;R acceptance time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Conclusions

On the basis of demand and occupancy patterns over the past year, we need an increase of 30 beds (Ward 21) in order to safely manage winter 2018. It is also clear that we have opportunities to improve patient flow through improved management of long stay patients, the implementation of Home Based Wards, new medical staffing roster and Structured Interdisciplinary Based Rounds together with rigorous monitoring of performance against our patient flow metrics. In addition, the Francis Health acute flow diagnostic may identify further opportunities to improve patient flow. Although these improvements will not take effect quickly enough to obviate the need for the additional capacity this winter, they should enable more substantial reductions in resources after winter demand has abated and will inform planning for future capacity.

Appendix

1. Francis Report
Appendix 1 – General Medicine Bed Capacity

22 May 2018

Phillip Baimer
Director of Hospital Services
 Counties Manukau Health
 Executive Management Level 5 Galbraith Building,
 Middlemore Hospital,
 100 Hospital Road,
 Auckland

Dear Phillip

Re: Acute Flow Diagnostic
Thank you for this opportunity to assist Counties Manukau District Health Board (DHB) assess its endeavours to improve timely and safe access for acute patients at Middlemore Hospital. The details of our proposed approach are outlined.

Our Understanding of Your Needs
You have a rapid need to quickly assess the current state of acute flows within Middlemore Hospital in advance of winter in order to gauge the potential enablers and barriers to timely patient flow and whether additional ward capacity is required.

Due to a wide range of efforts over past years CMDHB have not been required to increase the number of acute inpatient beds at Middlemore Hospital. Current estimations are that additional beds will be required in order to respond to this winter’s expected pressures.

Our Proposed Approach
You have asked Francis Health to assist you undertake this review over the next 2 weeks. We will assist you thus:

- Provide you with instructions for your analysts to complete an analysis of acute flow
- Support your analysts complete the diagnostic pack which will require 3-5 days of senior analyst effort (Ed Robertson Senior Consultant)
- Review the analysis (Stuart Francis Executive Chair, Nai'a Naseem Principal and Dr Ian Sturgess Associate Medical Director)
- Interview key personnel at Middlemore
  - General Manager Emergency Department, Medicine & Integrated Care
  - Clinical Head Emergency Department
  - Clinical Director Medicine
  - Clinical Director Older Persons
- Prepare a 10-12 slide summary diagnostic that will:

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Counties Manukau District Health Board
2018

27 June
- Identify potential improvement opportunities based on best practice and benchmarking with other DHBs we have worked with over the past 3 years (7 in total)
- Indicate a work programme that would be required to address.

**Why Francis Health?**

Francis Health are an experienced performance improvement and organisational development health consultancy who can support CMDHB’s leadership to undertake planning and implementation for acute flow improvement initiatives. We appreciate that there is a need to undertake this work at pace.

We have a successful track record helping hospitals across New Zealand, Australia and the United Kingdom to deliver operational performance improvement and cost management. In particular we have undertaken several improvement programmes in New Zealand utilising our Improvement Portfolio methodology which provides a systemic approach to change management.

Our collaborative working approach means that in most of our assignments we conclude by reducing our delivery and taking on a coaching role with staff. We find this approach improves both the capability within the client organisation and ensures a sustainable solution that is owned by department. Our approach develops a momentum for change and optimises service delivery and quality in a sustainable way.

Francis Health believe that it is important that together, improvement efforts be:

- A participative, partnership-based process with the clinical leads and managers being part of the solution; engagement and capability-building within the service teams
- Be ‘low key’ where staff and stakeholders are engaged in an unassuming manner and expectations and anxieties are managed with tact and care
- Be as rapid as is practicable; undertake this work at pace, to maintain momentum for change one that develops an evidence base to support the facility and resource needs of the service both now and into the future that accounts for forecast service growth
- Closely aligned with existing change projects underway across the DHB
- Supportive of internal service improvement and project management capability.

Our approach to acute flow instigates activity in each of the four components.
We have worked with seven DHBs over the past 3 years across many of these dimensions as illustrated in the following table.

<table>
<thead>
<tr>
<th>DHB</th>
<th>ED</th>
<th>Acute Medicine</th>
<th>Inpatient Wards</th>
<th>Frail &amp; Elderly</th>
<th>Medical Model</th>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitemata</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lakes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Hawke's Bay</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Capital &amp; Coast</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>MidCentral</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Waikato</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔️</td>
</tr>
</tbody>
</table>

We work to build a strong evidence-based change culture, and have a ‘metrics matrix’ comprising Outcome, Impact, Process and Balancing measures – for each programme overall as well as each workstream.

By way of illustration, the impact our work with (the most 5 advanced or complete) DHBs on the government’s system-wide measure the Short Stays in ED can be seen in the following graph based on data published by the Ministry of Health. It shows a 3.75% latest difference in SSED performance for Francis Health clients compared with the 15 other DHBs.
The logic, drawing from our work with Waitemata, Lakes, Bay of Plenty, MidCentral, Capital and Coast, Hawke's Bay and Waikato DHBs, is programmes to:

a. Engage with your clinicians and support the uptake of inter-specialty professional standards (both within ED and with admitting specialties)
b. Reduce harm to patients through improved flow and earlier senior review (including reduced harm from de-conditioning in frail older people)
c. Reduced bed occupancy resulting from improved models of care
d. Explore opportunities for innovative tools (e.g. clinical criteria for discharge) and redesigned roles (e.g. allied health)
e. Improve staff morale as a consequence of reduced hospital over-crowding
f. Seamless transfer of patients, and patients where they should be ("one admission, once").

Our Team
Our team will be led by Stuart Francis with support from Ian Sturgess and Nailed Naseen.

Stuart Francis, Executive Chair
Stuart is a senior management and health care consultant, working at senior levels, particularly facilitating organisational design and transformation, multi-agency initiatives and national programmes. He is the Executive Chair of Francis Health. Stuart leads the design and delivery of Francis Health's leadership development programs, with particular focus on organisational development and affecting cultural change. Stuart instigated the development and led our signature CDC programme in Queenstown, New Zealand.

www.francishealth.co.nz
Naila Naseem, Principal

Naila is Principal with a clinical background and over 20 years of industry experience in Healthcare, Management and Consulting. Specialising in OD, Organisation Culture, Change Management, Performance Improvement and Coaching, Naila has played a leadership role in Acute Flow Improvement programmes with five DHBs and service transformation programmes with St John Ambulance in NZ and Western Australia.

Naila has a proven track record in coaching at Executive and Senior Management level for clinical and operational staff that have been promoted to leadership positions within the Health sector.

Ed Robertson, Senior Consultant

Ed is a Senior Consultant with Francis Health. He brings a broad skillset, including the ability to crystallise ideas and execute complex tasks, to support successful project delivery. Ed has a strong background in business and process analysis, solution generation and project management.

Ed has led the diagnostic, analysis and business intelligence support for a number of acute flow programmes including Waitemata and Bay of Plenty DHBs. He has worked in an analyst role on the operating theatres improvement programme at CCDHB and HVDHB. Recently he has also been supporting the development and implementation of a Radiology service redesign.

Dr Ian Sturgess, Associate Medical Director

Ian is an international renowned clinical expert in improving Emergency Care and has partnered with more than 140 hospitals across Australia, New Zealand and the UK, working closely with local teams seeking to enhance their Emergency Care. He is a pioneer of many of the leading methodologies in acute care management such as SAFER Care Bundle and Red2Green.

Philip, we are excited by the opportunity to work with you and the team in helping assess your preparations for winter. We hope that the arrangements outlined in this proposal meet with your satisfaction, and would welcome a discussion with you about any queries you might have.

Please email me at rory.matthews@fgconsult.com or call me at your convenience on 021 309 969 should you wish to discuss this proposal. If you are happy with the proposal I would be grateful if you could please sign and return the terms of engagement attached.

Yours sincerely

Francis Health

[Signature]

Rory Matthews
Managing Partner
Recommendation

It is recommended that the Board:

**Note** that the TAP project’s final proposals, benefit numbers and ‘next steps’ recommendations are currently being reviewed with the business and the ELT.

**Note** that the TAP project team is validating annual benefits in the range of $12M (low) to $16M (high).

**Note** that the final TAP report will be presented to the Board in August 2018.

*Prepared by:* Dr Kathryn de Luc, General Manager Integration, Franklin Locality (currently seconded to the role of Turn Around Programme Lead)

*Submitted by:* Gloria Johnson, Acting Chief Executive Officer.

Glossary

TAP – Turn Around Plan
ELT – Executive Leadership Team
BAU – Business as Usual
RC – Resource Centre
ZBB – Zero-based budgeting

Update

Stage One of the Turn Around Plan (defined as December 2017 – June 2018) is nearing completion and the project team is currently working to validate the final benefits position with the business and the ELT. The TAP project team is aiming to submit their final report, with validated benefits and ‘next steps’ recommendations, to the Board in August 2018.

The TAP team’s approach/methodology for identifying saving opportunities - to bridge the financial gap - was endorsed by the Board in February 2018. It emphasised the need to develop a plan with sufficient rigour and transparency to meet the expectations of the NZ Public Health and Disability Act 2000 and standards of good practice in the management of public sector organisations. In particular emphasis was placed on the following elements:

- Ensuring there was a strong clinical voice in the decision-making.
- Te Tiriti o Waitangi considerations were built into the decision-making processes at multiple levels.
- There was a strong equity focus.
- The approach used would be based on evidence and learnings from local, regional, national and international colleagues and literature.
As previously reported, the TAP Working Group’s efforts led to it concentrating its focus on nine priority areas where it is believed there is the greatest potential for added value and the identification of financial savings. These are:

1. Priority Area 1: Tackling clinical variation
2. Priority Area 2: Improving management of complex conditions
3. Priority Area 3: End-of-Life Care
4. Priority Area 4: Improving patient flow
5. Priority Area 5: Non-hospital alternatives to Emergency Department
6. Priority Area 6: Improving match between cost and revenue
7. Priority Area 7: Outpatient remodeling
8. Priority Area 8: Corporate/Organisation wide
9. Priority Area 9: Workforce

CM Health has successfully delivered efficiencies and savings in previous years which have enabled services to absorb additional clinical demand and complexity.

The current financial position of CM Health requires us to identify and remove cost. Currently the TAP team is working to validate $12M - $16M per annum potential benefits identified to date. In particular the team is seeking to ensure that:

- Benefits are not double counted both within individual TAP projects and also with regard to other projects outside of TAP. E.g. the proposed extra bed capacity for General Medicine over winter;
- Benefits are achievable and can be operationalised (e.g. translated into real value savings and linked to a cost centre);
- We bring all the elements together to make sure we have a whole-of-system view which identifies where the savings are, where we may need to make some compensatory investments, the size of that compensatory investment and the timing implications.

In addition to validating benefits, the TAP project team is identifying and assessing alternative mechanisms that could assist with further bridging the financial gap. These levers, along with the working groups’ ‘next step’ recommendations’ will be detailed in the final report to Board.

At the same time independent advice/review is being sought to provide ‘proof of concept’ advice in the areas of Patient Flow, Zero-based budgeting (or similar approach) and review of our underlying deficit.
Briefing Paper
Counties Manukau District Health Board
Safety for all: ‘coercion-free’ practice at Counties Manukau Mental Health Services. Goal of Zero Seclusion 2020

Recommendation

It is recommended that the Board:

Receive the Safety for All report.

Prepared and submitted by: Tess Ahern, General Manager, Mental Health & Addictions Service.

Background

The Board asked that Mental Health Services provide a report on this programme to eliminate the use of seclusion in all Mental Health services throughout the country once the work is underway.

Executive Summary

The use of coercion is a balance between depriving a person’s autonomy and dignity and preventing endangerment of the body or health of self or others. Restrictive measures, such as personal restraint are implemented to managing highly challenging situations and should be used as a last resort in psychiatric inpatient care.

Behaviours of concern such as aggression in an inpatient setting require a response that is safe, fit for purpose, uses the appropriate response to level of aggression evident and should be used for the least amount of time as possible. The use of seclusion is not always used in situations where a person is behaving in a way that is perceived as being dangerous, however it is acknowledged that seclusion is the most extreme form of ‘restrictive practice’ utilised in acute inpatient mental health services.

The Mental Health (Compulsory Assessment and Treatment) Act 1992, is the legislation that outlines the Use of Force (§122B) and § 71 describes the use of seclusion. New Zealand Standards (NZS8134.2:2008) defines restraint and clearly articulates that it must not be used as a routine measure and is a serious intervention of last resort.

The Counties Manukau Health Mental Health Response


The information shown in the link provides some data about seclusion rates including the following graph which demonstrates seclusion rates by DHB.
The CMH group that attended included Wanda Condell, Service Manager Acute Services, Cassandra Laskey Consumer, Family Advisor and Peer Support Professional Leader. Dr Coni Kalinowski Clinical Head Acute Services, Theresa Nu’u Charge Nurse Manager, Anne Brebner Clinical Nurse Director.

Outcome measures that are planned are measures that are currently collected

- % of people admitted to Tiaho Mai who are secluded
- Average seclusion hours per person to Tiaho Mai
- Average seclusion events per person admitted to Tiaho Mai.

Next steps include

- Commence co-design principles of stakeholder engagement
- Commence PSA discussion

Current Practice includes: CMH mental health acute services utilise a safety first approach in adult acute inpatient mental health services by

- utilising agreed staffing levels with the PSA,
- rostering practices that include skill mix and gender appropriateness wherever possible.
- An admission process that includes a focus on engagement and risk assessment and use of the Dynamic Appraisal of Situational Aggression (DASA) scale
- admission plans for people who have had a previous aggressive behaviours.
- we utilise the regional behavioural management prescribing guidelines which help to support assertive clinical management.
- there are weekly reviews of all incidents that involve aggression, restraint, seclusion and AWOLs.
- there are monthly liaison meetings with the Police and with the District Inspectors.

Future plans include reviewing the model of care to include; cultural needs are supported, people are supported to wellness using a trauma informed care approach and active assessment and management of people who present with addiction/substance misuse needs.
Counties Manukau District Health Board
South Auckland Social Investment Board - Director’s Report

Recommendation

It is recommended that the Board:

Receive the South Auckland Social Investment Board Director’s Report.

Prepared and submitted by: Margie Apa, Director, Social Investment Board Implementation Office
## 1. Update on the SIB Intervention and Evidence and Insights Workstreams

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Status</th>
<th>Intervention Progress Update</th>
<th>Evidence and Insights (E&amp;I) Progress Update</th>
</tr>
</thead>
</table>
| 1. Universal Services | On Track                | Universal services - Maternity, Well Child Tamariki Ora, Primary Care, Oral Health, and ECE - are being considered and addressed through the SIB focus areas including Start Well Māngere, ECE, Housing Support Service and Family Harm. Work is progressing with the Auckland Regional Dental Service (ARDS) on increasing coverage and engagement with services provided to South Auckland. | • The E&I team are working with the intervention leads from all the SIB prototypes to identify improvement opportunities for universal services. For example, through HSS, an analysis of immunisation coverage revealed that the children in HSS had received their immunisations through outreach services at a significantly higher rate than for the wider Counties Manukau population. This demonstrated the potential value of the outreach model for whaanau experiencing significant life stressors.  
• The E&I team are also working with the Start Well Māngere team to set up the evaluation of this prototype to contribute to our understanding of how universal services can better meet the needs of South Auckland children and their whaanau e.g. understanding how WCTO services can better meet the needs of children at risk of poor health and social outcomes - what does ‘proportionate universalism’ mean for South Auckland?  
• Options are being explored in the Family Harm workstream to develop a process for ensuring that children experiencing family harm are linked to universal service uptake information to ensure children are proactively offered universal services. |
| 2. Optimising Internal and Cross-Agency Processes, Systems and Infrastructure | Resetting and On Track | The SIB Working Group are currently working through these opportunities. The intention is to identify key agencies and people to take the lead on each action at the next Working Group meeting in June.                                                             | • The E&I team are setting up process measures across all SIB initiative areas to help identify gaps and opportunities for agencies to optimise internal and cross-agency processes. For example, the Family Harm snapshot work revealed a number of opportunities to improve agency ‘core business’ and how we can better take a collective approach to supporting whaanau experiencing family harm. |
| 3. Intervention Prototypes | 3.1 Family Harm Whāngaia Nā | On track                                                                                                                                       | • A Case Management System (CMS) has been implemented which has enhanced the ability of the system to monitor uptake of referrals and therefore outcomes achieved by NGOs by ‘closing the loop’ on cases.                                                                                     | • The E&I team have produced initial outputs from the retrospective and prospective snapshot ‘deep dive’, including client journey maps and a summary of agency outcomes. |
| **Pā Harekeke (WNPH)** | • Operational resourcing of the Safety Assessment Meeting (SAM) table continues to be an issue, with continuing inconsistent attendance and information provision, impacting upon the building of trusted relationships across the table, and delays in the assessment of low risk cases.  
• Work continues with agencies to achieve broader organisation buy-in to the benefits of participation and increased resource investment at the front end. This work has included the facilitation of process improvement workshops and the ongoing follow up of the prospective cases which will be translated into client journeys to support the identification of opportunities for process redesign.  
• Opportunities to prototype a local collective commissioning approach have been identified. Discussions have been held with Social Investment Agency (SIA) and the National Family Violence Multi Agency Team to establish national support to proceed with these opportunities. These discussions are ongoing. |
| **3.2 Housing Support Services (HSS)** | • The team have received 53 referrals, completed 50 first assessments, and are currently engaged with 48 families. The team have stopped taking on new referrals and are using this opportunity to ensure that families are receiving the wrap-around support they need, and are doing a ‘deep dive’ on learnings.  
• The in-home Family Therapy and in-home Financial Capability programmes are progressing well with good engagement and learnings being gathered.  
• **In-home Family Therapy:**  
  - ProCare are delivering the in-home Family Therapy programme for the HSS families, and are actively working with 4 families.  
  - The team are taking a holistic, whaanau-centred strengths based approach to their practice. Models used include CBT, goal setting, and a wellness wheel to identify strengths and protective factors.  
  - The team are working with Oranga Tamariki social workers on cases that have OT involvement, to ensure the families receive coordinated care.  
  - The larger households (e.g. some households have 13 people and three process improvement opportunities. The three-month follow-up of a subset of whaanau is now underway. An ethics application for this ‘snapshot’ work was submitted to the NZ Ethics Committee and approval was granted.  
• The E&I team are working with the Police National Headquarters (PNHQ) Research and Evaluation team to investigate the potential to undertake a process evaluation intended to identify the elements of the South Auckland model that are providing the greatest contribution to outcomes; and to complete a case-control study looking at outcomes from the WNPH model (initial outcomes report due July 2018).  
• The E&I team are working with the Counties Manukau Police Intelligence Team on an automated monitoring dashboard for WNPH based on the NIA database, and also working with PNHQ on the CMS dashboard for South Auckland.  
• Analysis is underway with two NGOs mapping referrals from the SAM Tables and engagement rates with whaanau identified through this pathway. |

| On track | The E&I team are working with the HSS team to finalise an Excel-based Monitoring Database, which captures key operational and monitoring / reporting data.  
• Ethics application for the HSS evaluation work was submitted to the NZ Ethics Committee (NZEC) and approval received. Qualitative interviews with Housing Support Service staff will start shortly.  
• The E&I team is working with Procare and Vaka Tautua to set up evaluation to ensure we are capturing key learnings and outcomes from the two in-home prototypes for HSS.  
• Learnings and process improvement opportunities are already being identified through the prototypes, including uncovering previously unidentified disability within families and ensuring appropriate support for these children.  
• Liaising with Tamaki Regeneration Programme to identify alignments in our respective E&I work around housing. |
generations living in the same home), complexity and cumulative distress experienced by families, have meant that most families require the highest level of intensive Family Therapy support (e.g. more intensive and consistent therapy sessions with a Psychologist).

- The Health Navigator that works alongside the Psychologist is also delivering the Triple P parenting programme to role model positive parenting. In one household she is working with 3 generations of mothers who have recently given birth. Transition planning with Start Well is being discussed for these mothers.
- The Psychologist is identifying learning disability needs amongst some of the children. She has supported one child who had a prolonged period of absence from school back into the education system, and navigated support for another child who had undiagnosed autism.

**In-home Financial Capability:**
- Vaka Tautua are delivering the in-home Financial Capability programme for HSS families, and are actively working with 10 families
- The team take a holistic whaanau-centred, strengths based approach to their practice which is broader than just budgeting advice. They deliver an 8 week programme – topics range from goal setting, health and wellbeing and disability entitlements, and the programme is tailored to the needs of the family.
- The team work flexibly, completing most their work after hours to accommodate families.
- Given that many of the HSS families are socially isolated and culturally disconnected, delivering in-home services could contribute towards further isolation. The HSS team are mindful of this, and are giving consideration as to how they can support families to re-connect and build support networks (e.g. peer-peer support)
- An initial meeting was held between Shannon Gatfield, HNZC Operations Manager for the Sustaining Tenancies Pilot, Karen Hitchcock (HNZC rep on the SIB Board), and SIB staff to learn more about the Sustaining Tenancies Pilot, share learnings from the HSS prototype and identify opportunities for future alignment.

### 3.3 Start Well Māngere

<table>
<thead>
<tr>
<th>On track, but difficulty</th>
<th>support, including sharing what we are learning and taking a strategic approach to what prototypes we are testing in each setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>The team have received 27 referrals, and are actively engaged with 20 mothers and 11 babies</td>
<td>The E&amp;I team are working with the Start Well Māngere team on setting up an Excel Monitoring Database, which will capture key operational data and assist with</td>
</tr>
<tr>
<td>The team are at capacity due to the high level of need of the mothers</td>
<td></td>
</tr>
</tbody>
</table>

Counts Manukau District Health Board 27 June 2018
### Recruiting Highly-Skilled Frontline Staff to Meet Demand is Impacting Service Delivery

- The team are developing an acuity model to better understand and track caseload volume, intensity and complexity of cases.
- Continue to gather workforce insights on the skillsets and capability needed to work with highly complex families.
- Recruitment has been challenging to attract the skill set required to replace a senior social worker due to only being able to offer a 6 month fixed term contract until December (which is when the current SIB funding ends).
- Established a monthly Multi-disciplinary meeting (MDM), which involves Start Well team, and other lead professionals involved in the clients care. Purpose of the meeting is to facilitate best practice, remove barriers, examine learnings, review professional inputs and guide practice towards positive outcomes for whānau in a responsive and integrated way. Each case is allocated 20 minutes on the agenda.
- Developing a process to get notifications of Family Harm from the North SAM table to the Start Well Team Leader to identify potential risks and ensure that the mothers and babies are getting the necessary support they need.

### 3.4 Mental Health, Alcohol and Other Addictions (AOD) Resetting and On Track

- A new Project Manager commenced work in April.
- The key priority has been resetting the project and developing a work plan that builds on the ABC brief intervention training completed to date, and identifying and joining up the mental health and AOD opportunities arising out of the other SIB intervention areas.
- The E&I team is working closely with the new Project Manager to establish baseline data as required and help set up evaluation for embedding the Alcohol brief intervention (ABC) approach for frontline staff across sectors.

### 3.5 Early Childhood Education (ECE) On Track

- Co-design an approach with ECEs, parents and whānau to strengthen ECE quality and build positive parenting communities that support child development, and children’s readiness for school in Māngere.
2. Evidence and Insights Update

As described above, the Evidence and Insights (E&I) team continues to work across the five prototype areas and across the wider SIB work programme to deliver a ‘test and learn’ approach and identify collective social investment opportunities for Maangere and South Auckland. Other E&I activities include:

- **Evidence and Insights Plan**: a refreshed E&I plan for 2018/19 is in development. The plan will articulate key research activities within SIB as a whole, as well as for the five prototypes (Start Well, Housing Support Service, Family Harm, MH/AoD, and ECE). The plan will contain an indication of the timeframes involved, methodologies to be employed, resources required and outputs to be produced.

- **Evaluation**: The E&I team are continuing to work with Intervention Leads to develop ‘fit for purpose’ monitoring and evaluation for each intervention area, as well as the SIB as a whole.

- **Local data repository**: With the PIA endorsed by the SIB Working Group in October 2017, the team undertook a trial data linkage with data from Police (Family Harm), HSS and Start Well. This enabled a ‘joined up’ picture of SIB families known to more than one SIB workstream. Following this trial linkage, the linkage process and PIA is being revised and updated.

- **SIA / IDI**: The team has been working with our Social Investment Agency (SIA) analytics colleagues on shaping various analyses. We have also been liaising with SIA on the method for linking our SIB cohort into the Integrated Data Infrastructure (IDI) and defining a counterfactual group for evaluation and return on investment analysis.

- **Analytical networking**: The team continues to have new connections to analytical/evaluation staff in agencies facilitated by Working Group members and others. This includes working with The Southern Initiative and Tamaki Regeneration Corporation to identify opportunities to collaborate and learn from each other, allowing us to take a strategic approach to what we ‘test and learn’.

3. SIB ‘cohort’

SIB’s initial Cabinet mandate was to focus on 1,480 at-risk 0-5 year olds in Maangere. Subsequent updated analysis (based on 31 December 2015 IDI ‘snapshot’) showed 1,300 out of a total of 7,900 0-5 year olds living in Maangere had 2 or more of the 4 Treasury-specified risk factors.\(^1\) Table 2 below summarises the number of children and wider whaanau members (where able) identified through the work of the SIB intervention prototypes (i.e. the SIB ‘cohort’) for May 2018.

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\(^1\) Based on the number of children having two or more of the four Treasury risk indicators: having a Child Youth & Family finding of abuse or neglect; being mostly supported by benefits since birth; having a parent with a prison or community sentence; and having a mother with no formal qualifications. Updated Māngere figures are based on 31 December 2015 ‘snapshot’ of children aged 0-5 years living in Māngere: around 1300 out of 7900 (17%) had two or more of the Treasury risk indicators.
## Table 2. SIB Cohort identified to May 2018 (Maangere SIB Area only)

<table>
<thead>
<tr>
<th>Service</th>
<th>Families/Whaanau</th>
<th>Age 0-5 years</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Support Service</td>
<td>48 families actively engaged and assessed</td>
<td>89 (based on age at first assessment, 73 based on current age)</td>
<td>326</td>
</tr>
<tr>
<td>Family Harm</td>
<td>Whāngaia Nā Pā Harekeke (WNPH) – Maangere SIB area since 15 March 2017</td>
<td>3080 family harm incidents resulting in a Police call out</td>
<td>1,090</td>
</tr>
<tr>
<td></td>
<td>Currently working with Police on whaanau view</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start Well Māngere</td>
<td>20 teen mothers, their infants and wider whaanau</td>
<td>10 babies</td>
<td>30</td>
</tr>
<tr>
<td>ECE</td>
<td>Working with 24 ECEs</td>
<td>1000 licensed places in Maangere</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>1,190 (not including ECE places)</td>
<td>7,900</td>
</tr>
</tbody>
</table>

## 4. Workforce Development Insights

Our prototypes in Family Harm, Housing Support Services and Start Well Māngere have revealed a number of key workforce development insights:

- Reinforced the workforce flexibility, skill and intensity of effort required to engage meaningfully with families to impact life outcomes. Culturally responsive practice is essential.
- Agencies need to rethink how they commission frontline practice, e.g. more emphasis needs to be placed on appropriately resourcing engagement - the time it takes to effectively engage and build trusted relationships is frequently understated and underfunded.
- Continuity of care should be a concept that is practiced across sectors, not just person-dependent.
- The frontline frequently deal with crisis situations (e.g. finding emergency housing for young at-risk mothers). The basic necessities need to be addressed first to create bandwidth for people to then think about their future wellbeing, goals and aspirations setting. This demands time, effort and cultural competence of frontline staff.
- Investment in workforce capability building and pastoral care is important to develop and retain highly skilled staff.
Counts Manukau District Health Board Meeting
Resolution to Exclude the Public

Resolution:
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| Public Excluded Minutes of 16 May 2018/Actions | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Confirmation of Minutes  
As per the resolution from the public section of the minutes, as per the NZPH&D Act. |
| Construction Project Update - verbal | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Activities  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.  
Commercial Position  
The disclosure of information would not be in the public interest because of the greater need to protect the commercial position of a third party. |
| NZNO Strike Contingency Planning | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Negotiations  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations. |
<table>
<thead>
<tr>
<th><strong>Rheumatic Fever Prevention Programme Revenue Agreement</strong></th>
<th>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Negotiations</strong></td>
</tr>
<tr>
<td><strong>Funder Contract Price Increase Recommendations 2018/18</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<tr>
<td></td>
<td><strong>Negotiations</strong></td>
</tr>
<tr>
<td><strong>Master Procurement Agreement</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<td></td>
<td><strong>Commercial Position</strong></td>
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<tr>
<td></td>
<td><strong>Negotiations</strong></td>
</tr>
<tr>
<td><strong>Lease of CMDHB Fleet Vehicles</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
</tr>
<tr>
<td></td>
<td><strong>Negotiations</strong></td>
</tr>
<tr>
<td><strong>NZHP Statement of Performance Expectations 18/19</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<tr>
<td><strong>Vector Power Contract for Middlemore Site</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
</tr>
<tr>
<td><strong>First Draft Annual Plan and Statement of Expectations 2018/19</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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